MassHealth

Section 1115 Quarterly Report

Demonstration Year: 21 (7/1/2017 – 6/30/2018)

Quarter 3: (1/1/18 – 3/31/18)

Introduction

The Commonwealth of Massachusetts' current 1115 Demonstration agreement (Project Number II-W-00030/I) Extension was approved on November 4, 2016, effective July 1, 2017 through June 30, 2022. This extension seeks to transform the delivery of care for most MassHealth members and to change how that care is paid for, with the goals of improving quality and establishing greater control over spending. The Demonstration also addresses the epidemic of opioid drug use in Massachusetts. The Demonstration extension seeks to advance six goals:

- Goal 1: Enact payment and delivery system reforms that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care
- Goal 2: Improve integration of physical, behavioral and long-term services
- Goal 3: Maintain near-universal coverage
- Goal 4: Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals
- Goal 5: Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services
- Goal 6: Increase and strengthen overall coverage of former foster care youth and improve health outcomes for this population.

In accordance with the Special Terms and Conditions (STCs) of the Demonstration and specifically STC's 78 and 79, the Massachusetts Executive Office of Health and Human Services (EOHHS) hereby submits its quarterly operational report for Demonstration Year 21, Quarter 3 ending March 31, 2018.

Enrollment Information

The enrollment activity below reflects enrollment counts for SFY 2018 Quarter 3, as of March 31, 2018.

Eligibility Group	Current Enrollees (to date)
Base Families	814,810
Base Disabled	227,164
1902(r)(2) Children	15,981
1902(r)(2) Disabled	16,160

Base Childless Adults (19-20)	27,377
Base Childless Adults (ABP1)	31,706
Base Childless Adults (CarePlus)	286,880
BCCTP	1,248

Eligibility Group	Current Enrollees (to date)
CommonHealth	27,017
e-Family Assistance	7,934
e-HIV/FA	667
SBE	22
Basic	N/A
DSHP- Health Connector Subsidies	N/A
Base Fam XXI RO	0
1902(r)(2) XXI RO	0
CommonHealth XXI	0
Fam Assist XXI	0
Asthma	N/A
TANF/EAEDC*	N/A
End of Month Coverage	N/A
Total Demonstration	1,456,966

*TANF/EAEDC is a subcategory of Base Families

Enrollment in Managed Care Organizations and Primary Care Clinician Plan

Plan Type	QE 09/17	QE 12/17	Difference
MCO	789,436	637,742	-151,694
PCC	420,114	310,094	-110,020
MBHP	486,277	499,411	13,134
FFS/PA*	626,575	609,388	-17,187
ACO	0	275,166	275,166

*PA included in FFS enrollment count

Enrollment in Premium Assistance and Small Business Employee Premium Assistance

During this reporting quarter, MassHealth provided premium assistance for 43,193 health insurance policies (including Student Health Insurance Plan policies), resulting in premium assistance to 54,698 MassHealth eligible members. Note that in the delivery system enrollment numbers above, members in FFS and in MBHP may receive also premium assistance.

The Small Business Premium Assistance Program is still operating and the enrollment numbers

remained the same since the last reporting period. During the quarter we had an average monthly enrollment of 14 members in the SBEPA program. The gradual drop in enrollments over time continues to be mainly due to either loss of private insurance, or the member was determined eligible for a richer benefit and has been transferred to a Premium Assistance benefit under another category of aid.

A new premium assistance project was implemented by MassHealth in fall of 2016 called Student Health Insurance Plan Premium Assistance (SHIP PA). This project allows current MassHealth members who are full-time college students and have access to SHIP through their college or university to enroll in their schools' SHIPs and receive MassHealth Premium Assistance. MassHealth eligible college students were previously able to waive out of electing SHIP but on November 4, 2016, MassHealth received approval through the 1115 demonstration to require that any full-time student enrolled on MassHealth must enroll in the SHIP plan, if available. As of March 2018, 31,500 students were enrolled in the program, which far exceeded expectations for the project.

Premium Assistance Program	**Disabled Members**	**Non-Disabled Members**	**Total MassHealth Enrolled Members**
Standard	1,984	9,691	11,675
CommonHealth	3,305	0	3,305
Family Assistance	17	7,681	7,698
CarePlus	0	506	506
Small Business Employee Premium Assistance (SBEPA)	0	14	14
Student Health Insurance Premium Assistance (SHIP PA)	0	31,500	31,500
Total for Q3	**5,306**	**49,392**	**54,698**

Outreach/Innovative Activities

Certified Application Counselor Training and Communication

MassHealth continues its extensive training and communication efforts to continually educate and inform the over 1,400 Certified Application Counselors (CACs) across 270 CAC hospitals, community health centers, and community service organizations. Collaboration with the Massachusetts Health Connector on these activities provides timely, uniform knowledge and messaging across all enrollment Assisters (CACs and the Health Connector Navigators, Independent Enrollment Assisters).

CAC training and certification starts with successful completion of ten online, comprehensive certification training courses (over 850 pages) to prepare CACs to assist consumers in obtaining

MassHealth/health insurance per ACA regulations, covering all aspects of MassHealth, subsidized and unsubsidized health coverage, as well as instruction on utilizing the paper and online applications in the most effective and efficient way. Learning for CACs continues throughout the year in the form of mandatory online trainings covering updates and MassHealth initiatives, Assister emails, conference calls, webinars, meetings, and other outreach activities. All CACs must also take and pass a comprehensive assessment each fall to meet annual recertification requirements.

Frequent email communications are distributed to all enrollment Assisters on a wide variety of MassHealth eligibility and related topics, as well as refreshers, in order to help Assisters assist MassHealth applicants/members/consumers effectively. Thorough communications and trainings are provided for all application changes and Health Insurance Exchange (HIX) system releases. Regular one-hour conference call trainings are also provided for the Assisters, providing a more in-depth explanation and include detailed question and answer sessions with subject matter experts. Certain trainings are considered mandatory and CACs are required to complete the training within a specific time period in order to maintain CAC certification. Mandatory events cover key topics such as policy or process updates, certification course updates, and other eligibility/enrollment activities.

This quarter the CAC Training team's primary focus continued to be on activities in support of the new MassHealth health plan options and introduction of Accountable Care Organizations (ACOs) that went into effect March 1, 2018. With MassHealth member mailings sent to all MassHealth managed care eligible members late last fall with personalized information about changes to their health plan enrollment effective March 1, timely and ongoing communications and updates for the CACs was central to a smooth transition for members.

"Assister Update" newsletters and conference calls continued in earnest this quarter around the new MassHealth health plan options to help ensure CACs were kept up to date about the changes, their impact on members, and share information learned from frequently asked questions coming into customer service. Additional CAC support and learning opportunities were also offered and included presentations at the quarterly Massachusetts Health Care Training Forums (MTF), job aids to help navigate health plans, the MassHealth Choices website and provider directories, and opportunities to participate in webinars that reviewed the changes.

Bi-weekly check-in calls throughout the quarter focused on the new health plans, managed care eligible member transition, and continuity of care after March 1st and were hosted by MassHealth policy experts. In addition to providing important updates, reviewing the new health plans and supports, and reinforcing best practices, each call included an open question and answer period for the CACs. Questions and feedback from the calls were tracked and shared with internal operations and program staff for research, clarification, and follow up with vendors, health plans, or operational staff as needed. Follow up and issue resolution was provided to individual CACs or all CACs as appropriate.

Many of the conference calls focused on MassHealth's commitment to working with all relevant parties to ensure continuity of care for the many members who were moving to new plans, whether they were going to or from an ACO Partnership Plan, a Primary Care ACO, an MCO, or

the Primary Care Clinician (PCC) Plan. The "Continuity of Care–Supporting Member Transitions to New MassHealth Plan Options" document and a subsequent Continuity of Care FAQ document were reviewed in detail during the February and March calls and reinforced how MassHealth is working with ACOs, MCOs, and providers to ease the transition to new plans. These key documents were also shared with the CACs in Assister Update emails and stored as a resource in the Learning Management System.

MassHealth Health Plan check-in calls are scheduled through Q4 to keep CACs informed and help them provide members with continued support for the transition process, member enrollments, and the close of the Plan Selection Period (PSP).

The majority of the 36 Assister Update emails sent and 9 calls/webinars held this quarter focused on the new MassHealth Health Plan initiative ensuring CACs had knowledge of and access to the latest information, resources, and updates including:

- Job aids to help CACs as they assist members explore, understand, and enroll in (if needed) the new health plans. Included was an easy-to-use, detailed one-page MassHealth Health Plan Directory tool that provides comprehensive directions on where to go to find primary care providers (PCPs), specialists, behavioral health specialists, and hospitals by plan type. A MassHealth Health Plan Directory Desk Guide provided tips and best practices for using both the MassHealthChoices.com and the MassHealth Provider Directory to search for providers and to find/compare plans.
- Guidance on how to access and use the MassHealth online enrollment form. With online health plan enrollment being the fastest and best way to enroll in a plan, Assisters were strongly encouraged to use, and took great advantage of, the MassHealth online enrollment form when helping members. MassHealth also implemented some temporary changes to the enrollment form prior to March 1st, based on CAC and member feedback, which allowed members to indicate whether the enrollment was to take effect immediately or on March 1st.
- A specific MassHealth Health Plans folder in the Learning Management System where job aids, documents, and important links gave CACs easy access to key resources for the new health plan rollout.
- Assister Update emails that shared updates and guidance on topics such as the expanded MassHealth customer service hours in March (specifically for health plan enrollment), member guidance on carrying and using MassHealth and Health Plan cards, CAC resources for the latest health plan enrollment information for a member, and ongoing MassHealth in-person enrollment events.

In addition to the new MassHealth Health plan options, other key CAC activities for the Training and Communications team this quarter included providing information on the Health Connector and MassHealth End of Year Tax filing Process—including an Assister call, mandatory online training in the LMS, job aids, links to tax filer resources, and guidance on how to help members, and recent changes on the federal individual mandate—as well as Health Connector Open Enrollment and Closed enrollment and updates/Q&A at the four January regional MTF meetings.

<u>Member Education and Communication</u>

As noted above on March 1, 2018, MassHealth rolled out new health plan options to support the state's Payment and Care Delivery Initiative (PCDI). This rollout out impacted roughly 1.2M MassHealth managed care eligible members.

MassHealth developed and implemented a multi-prong member support strategy to rollout this effort. That approach covered three categories and each focused on different strategic goals and reaching different populations. The approaches were to create global awareness and education, support materials and member engagement, and enhancements to customer service support. During this quarter, MassHealth continued to implement those strategies.

1. **Global Awareness and Education**

The first category, creating a global awareness and education approach provided training, created communications and member friendly materials that shared broad information to mass audiences, educating members and our stakeholder communities on the new health plan options available to managed care eligible members. During the quarterly Massachusetts Training Forums (MTF) in-person meetings (total of 4 meetings reaching 4 regions statewide), we educated and trained our stakeholders, hospital staff, health center staff, the provider community and organizations that support our members, to help them understand available resources and timelines relevant to these health plan changes. In addition to the in-person meetings, additional webinars and conference calls were held to update our stakeholders and offered opportunities for training and information to those that weren't able to attend the in-person meetings. For the January 2018 MTF session, in total over **1,083** individuals participated and were trained and 235 individuals participated in webinars. To provide additional support and trainings, additional in-service trainings, webinars and conference calls were held to support inter-agency Executive Office of Health and Human and Services (EOHHS) staff and over 140 staff members participated. These webinars provided additional information related to member impact, addressed specific information that would impact the populations they work with, and answered questions.

2. **Support Materials and Member Engagement**

The second category is creating materials and engaging directly with our members during this transition. MassHealth created member-friendly materials and began to hold special events to support member enrollment choices and assist with any eligibility issues they were experiencing.

In October – December 2017, MassHealth developed member-friendly letters to inform members of their new health plan choices. In order to maintain important provider relationships and ease continuity of care, if a member's primary care provider was moving into a new health plan, they received a letter informing them that they would be following their primary care provider into a new health plan on March 1st, if they did not make another decision. Heads of household also received a new MassHealth Health Plan Enrollment Guide, which provided them with information about all the MassHealth health plans available. All materials were written in plain language, using infographics, and were translated into English and Spanish. Member materials were focused tested with individuals who work directly with members to ensure readability and clarity.

Materials were made available, upon request, in other languages. All member notices were sent in either English or Spanish, depending on the preferred language indicated by the member. In addition, all notices included a standard Babel sheet, with information consistent with requirements of ACA Section 1557 on how to access the information in 15 other languages as well as alternative formats such as braille and large print, and the availability of a language line offered by our customer service vendor and translators to support requested needs.

A new member website was launched in late 2017 called MassHealthChoices.com. It was created as an interactive way for members to Learn, Compare, and Enroll in their desired health plan. The website is available in English and Spanish. Additional materials including tools to understand how to select a health plan and a primary care provider that's important to the member, to understand the new Accountable Care Organization models and some of the benefits for members, to how to navigate our new MassHealthChoices.com website, along with easy to read and understand new health plan web content were developed and distributed broadly to our provider community, community agencies, stakeholders, and made available on the MassHealth website.

During the quarter and into Q4 MassHealth outreach staff held enrollment events to help members complete renewals and health plan selection. Enrollment events are opportunities for new applicants and current members to meet with MassHealth staff to ask questions about their coverage, and seek assistance in understanding how to use their health care. During January through March of 2018, MassHealth held 7 enrollment events across Massachusetts targeting diverse communities with high access needs and continued high under insurance rates. These events are to reach individuals where they are and conduct services and provide assistance in a way that meets the individual's needs. Language and American Sign Language interpreters are available at all events to assist consumers who are in need of those services. In total, approximately 300 members attended and were helped at these events.

3. Enhancements to Customer Service Support

And lastly, MassHealth continues to make enhancements to the customer service center to provide effective customer service support to members by answering questions, providing resources, and resolving member issues. This was accomplished by increasing customer service staff numbers and training all customer service staff on health plan changes. In addition, in an effort to address member information in a timely manner, updates were made to our member messaging system and a special line was set up to directly provide members with particular health plan enrollment information. Specific teams were developed at the customer service center to address specific health plan questions. A reporting strategy and a triage process were established to escalate cases, with enhanced communication processes between the health plans and our customer support managers. An escalation team was also created to handle specific urgent medical and pharmacy needs for members during the transition to new health plans.

<u>Provider Education and Communication</u>

During the third quarter, MassHealth conducted **Phase II: Operations** trainings as part of a multi-phase approach to educate providers about the operational changes due to the new plan

options. Phase II concluded in April and Phase III training dates are still being finalized.

This second phase of education (webinars and in-person events) is focused on:

- Overview of PCDI Communication and Education strategy
- Changes to the Eligibility Verification System (EVS)
- Plan-specific administrative and operational functionality
- Continuity of care policy
- Overview of member resources

In this quarter, MassHealth held 17 webinars with a total of 457 attendees and 4 in-person sessions with a total of 46 attendees

MassHealth has developed two additional fact-sheets targeted to Long Term Services and Supports and other covered services providers which educated them on PCDI, provided information on how to communicate these changes with their patients, and how these changes influence important aspects of their practice such as networks, billing, and prior authorizations.

In March, 2018 MassHealth published All Provider Bulletin 275: MassHealth EVS Codes and Restrictive Messages for 2018 Managed Care Health Plans for providers. There were also updates made to the a EVS Restrictive Messages quick reference guide, and Screenshot Examples to assist providers to further their understanding of EVS and system programming needs in preparation for the March 1st implementation.

Since the initial launch in December 2017, MassHealth continued to update the provider focused webpage, https://www.mass.gov/payment-care-delivery-innovation-pcdi-for-providers with materials and information as they became available. This is a primary landing page for providers to access key materials and learn more about payment reform activities.

During the quarter, MassHealth conducted a series of webinars and in-person events, conducted Provider Association Forum (PAF) meeting, presented at MassHealth Training Forum (MTF) events, created Provider Bulletins, created provider reference materials and enhanced MassHealth provider webpages on Mass.gov. These activities are part of MassHealth's approach to provide education to all 68,000 MassHealth providers during Spring 2018.

Additionally, MassHealth is continuing to work with external stakeholders such as Provider Associations, Sister Agencies, and ACO health plans.

Delivery System Reforms and DSRIP

Accountable Care Organizations (ACOs)

During January and February 2018, MassHealth held public meetings across the state and met with dozens of provider and other stakeholder groups to discuss the ACO program. MassHealth also worked to ensure that all health plans exchanged important information, such as authorization for services and prescriptions, for members who were

changing plans as a result of the launch of the program. ACOs also identified members with complex conditions for special outreach.

MassHealth launched its ACO program on March 1, 2018 with 17 ACOs serving about 850,000 members. During the month of March 2018, MassHealth hosted weekly Office Hours for several groups of providers and stakeholders, in person and by phone (e.g., hospitals and medical providers, behavioral health providers, community health centers, member advocates). MassHealth further provided guidance to members and providers about the continuity of care process for members as they transitioned into their new plans through written FAQs. In response to heavy call volume related to the ACO program launch during the month of March, MassHealth extended its customer service center hours on evenings and weekends to ensure that members could receive assistance.

During this quarter, MassHealth continued to provide robust guidance and support to ACOs and MCOs regarding the Community Partners (CP) program. MassHealth held joint meetings with the ACOs, MCOs, and CPs to share important milestones and concepts and provide a forum for constructive feedback, as well as one-on-one monthly meetings with MassHealth contract and performance management staff for each of the ACOs, MCOs and CPs. Additionally, MassHealth released comprehensive guidance on care management and care coordination in the CP Program; provided support for the development of operational processes to be shared by the entities; and continued working on data sharing arrangements across entities.

In February, MassHealth received and began its review of the ACOs' Full Participation Plans, through which the ACOs provided detailed information about how they plan to use DSRIP dollars to provide better, more integrated care to members. MassHealth also approved the majority of the ACOs' PY1 budgets and disbursed Performance Year 1/Q1 DSRIP payments to most of the ACOs. At the end of March, MassHealth received the ACOs' PY0 Progress Reports in which the ACOs reported out on the expenditure of their PY0 DSRIP funding. DSRIP funds support innovations that include free monthly mobile markets with fresh fruits and vegetables for patients and community members; intensive care management in support of frequent ER users; cell phones for members with complex medical/behavioral health care needs; and an opioid prescription management program for providers.

During this quarter, MassHealth put its internal performance monitoring strategy into place for each ACO, including establishing a quarterly cadence for contract management meetings with ACO staff and semi-annual meetings with ACO leadership. MassHealth continues to hold weekly Office Hours for all ACOs to provide support generally and to focus on specific areas including Quality.

Lastly, on the DSRIP side specifically, Massachusetts continued to work with the 17 contracted ACOs, approving the majority of the ACOs' Performance Year (PY) 1 Budgets. The ACOs submitted their Full Participation Plans and the State and Independent Assessor began their review of the plans. In Q3, the State disbursed approximately $52M in DSRIP funds corresponding to PY1 Budgets. ACOs are

utilizing the funds for a variety of different startup and ongoing tasks with a focus on primary care. Some examples of these DSRIP investments include: (1) support for behavioral health integration in primary care settings through the use of alternative payment mechanisms with providers, (2) complex care coordination programs that target the specific needs of MassHealth members, with a focus on behavioral health and social determinants of health, and (3) an Ambulatory Intensive Care Unit (ICU) Program that will care for members with serious medical conditions in their homes.

Community Partners (CPs)

MassHealth continues to work towards the launch and implementation of the Community Partners (CP) Program and the Community Services Agencies (CSA) DSRIP program, which are geared towards investing and supporting populations with high behavioral health (BH) and complex Long-Term Services and Supports (LTSS) needs in the Commonwealth. Both programs are set to launch July 1, 2018, which is one month later than previously anticipated.

MassHealth worked closely with contracted CPs on readiness review during this quarter. This included hosting monthly meetings with all contracted CPs and joint meetings with CPs and ACOs/MCOs, as well as providing guidance on and reviewing deliverables from CPs. Deliverables included Preparation Budget Period Milestones; enrollment forecasting and capacity determination in regard to the numbers of individuals that could be supported by each contractor; Full Participation Plans and BP 1 Budget and Budget Narratives; and baseline assessments of Electronic Health Records.

MassHealth convened CPs, ACOs and MCOs to further clarify and discuss expectations regarding contractually-required ACO/MCO and CP Agreements and Documented Processes on topics such as enrollee assignment and engagement and care transitions. While MassHealth anticipates ACO/MCO and CP Agreements to be completed by mid-April, Documented Processes clarifying roles and responsibilities between the entities must be completed prior to CP Program launch and will be due to MassHealth in two phases. MassHealth convened the parties over multiple meetings to answer questions and discuss key questions intended to assist in the development of required Documented Processes.

In January, Account Managers made status calls to all CPs to discuss progress on ACO/MCO and CP agreements, including initial challenges, successes and key barriers. Account Managers visited each CP in February to discuss progress on and status of the deliverables noted above and to review internal processes and workflows. In March, Account Managers made additional status calls to identify challenges, successes and barriers in development of Documented Processes and to check-in on deliverable progress.

Following MassHealth review of budget requests, BH CPs were provided additional funding to implement standardized assessments using an InterRAI assessment tool.

Due to challenges with MMIS functionality, MassHealth made changes to the assignment process and will make assignments directly to CPs for July 1 and October 1, 2018. ACOs and MCOs will be accepting referrals to the program starting in January 2019.

CP Preliminary Participation Plans and Prep Budget Period (PBP) Budgets and Budget Narratives were approved by EOHHS. Roughly $12.1M in DSRIP PBP funds were disbursed to Community Partners (CP) in January. CPs are utilizing their DSRIP PBP funds for a variety of different startup and ongoing tasks associated with conducting CP supports. Such investments include, but are not limited to, sourcing appropriate office space for the CPs, establishing documented processes with ACOs, hiring and training new staff, purchasing essential equipment for staff (e.g. computers, desks, phones, etc.) and purchasing/developing their own Electronic Health Records. In January, the State also completed contract execution with 19 Community Service Agencies (CSA) and approved their Preliminary Participation Plans and PBP Budgets and Budget Narratives. Approximately $2.9M in PBP DSRIP funds were disbursed to CSAs. In March both CPs and CSAs submitted their Full Participation Plans and Budget Period 1 Budgets and Budget Narratives. These deliverables are currently under review by the State and Independent Assessor.

DSRIP Statewide Investments

Statewide Investments (SWI) is a portfolio of eight investment streams designed to build and strengthen healthcare workforce capacity and delivery system infrastructure across Massachusetts, with the goal of helping ACOs, CPs, and CSAs succeed in MassHealth payment reform.

During Q3, the State signed a contract with Abt Associates to serve as the external partner to assist with standing up and managing the Technical Assistance (TA) investment, which comprises the largest proportion of SWI funding (~$44 million over five years). The SWI team also signed a contract with the Massachusetts League of Community Health Centers (MassLeague) to assist with standing up and managing student loan repayment programs, the Primary Care Integration Models and Retention Program, the Investment in Primary Care Residency Training programs, and a portion of technical assistance specifically focused on CHCs. The State also engaged in discussions with the Executive Office of Labor and Workforce Development (EOLWD) regarding an Inter-Agency Service Agreement (ISA) that would enable a partnership with the Commonwealth Corporation, a quasi-state agency with expertise in workforce development associated with EOLWD, to stand up and manage programs under the Workforce Development Grant Program, which will invest in training for Community Health Workers, Certified Peer Specialists, and frontline workers in ACOs and CPs. Additionally, the State released an RFP to solicit proposals for grant awards under the Alternative Payment Methods Preparation Fund and continued to make progress in the design of the Enhanced Diversionary Behavioral Activities investment. Lastly, the State continued working under the ISA with the University of Massachusetts Medical School (UMMS) to design a provider directory for MassHealth members that details the accessibility accommodations at MassHealth providers.

DSRIP Operations and Implementation

The fourth stream of Operations and Implementation provides funding for staff and vendor contracts to assist the DSRIP program. EOHHS has transitioned all State Innovation Model staff to DSRIP support in Q3. In Q3, EOHHS also contracted with the Disability Policy Consortium

for Ombudsman services.

On December 1, 2018, EOHHS contracted with Public Consulting Group (PCG) to serve as the DSRIP Independent Assessor. In Q3, PCG's ACO Team reviewed revisions to ACO PY1 Budgets and Budget Narratives for compliance with the Special Terms and Conditions, DSRIP Protocol, and EOHHS-issued guidance and feedback. In Q3 they reviewed the Full Participation Plans and provided initial feedback. PCG will review Prep BP Progress Reports next quarter. PCG's CP/CSA team began their review of all CSA BP1 Budgets, Budget Narratives, and Full Participation Plans. In Q4, they will complete their review and begin their review of the CP BP1 Budgets, Budget Narratives, and Full Participation Plans. In Q3 CMS provided guidance to the State that it would need to conduct a separate Midpoint Assessment (MPA); the State began conversations with PCG to develop the scope of the MPA.

In Q3, Massachusetts Health Quality Partners (MHQP), MassHealth's contractor supporting member experience administration, fielded and began collecting responses to the adult and children's Primary Care surveys for the six pilot ACOs. MHQP monitored response rates and implemented tactics, such as redesigning the envelope, implementing a second wave of the survey, to increase rates as needed.

In Q3, MHQP also continued work to develop Behavioral Health and Long-Term Services and Supports (LTSS) surveys for administration in 2019. Their work consisted of researching available tools, working with the MassHealth BH/LTSS member experience workgroup to identify key domains, priorities and gap areas in the survey tools. MHPQ proceeded to conduct a series of focus groups and in-depth interviews with MassHealth members, providers, Community Partners, and other key stakeholders to review and collect feedback on potential candidate survey tools. The feedback informed the domains, unmet priorities and gaps as part of the process and next steps toward finalizing of surveys.

To provide advice and feedback on the implementation of delivery system reform, Massachusetts has procured a Delivery System Reform Implementation Advisory Council (DSRIC). DSRIC is made up of ACOs, CPs, providers, patient advocates, and other stakeholders that meet on a bi-monthly basis to discuss various payment reform topics. In February, EOHHS presented on its proposed policies for populations with Special Health Care Needs (SHCN) as well as the processes for screenings and comprehensive assessments. Since this was the last meeting prior to the full launch of the ACO program, members also voiced their thoughts around continuity of care, service area exclusions, and other pre-launch concerns. EOHHS was responsive to this feedback, making several significant policy changes dealing with these issues (e.g. extension of Continuity of Care period, extension of the plan selection period), which were implemented during Q3, and have been discussed during calls with CMS.

Flex Services

MassHealth received feedback from CMS on the draft Flexible Services Program (FSP) protocol in late February. Based on that feedback, MassHealth spent a significant amount of time during this quarter revising its FSP protocol to better align its structure with the 1915(i) framework, including: clarifying the FSP's eligibility criteria; refining

the list of services (especially calling out when such services are not currently captured within the 1915(i) framework; developing screening, assessment, and care planning principles; and payment details, among other topics.

Infrastructure and Capacity Building

EOHHS released an additional $4.6 million out of a potential $5 million ("ICB Round 2") for SFY 2017. ICB Round 2 provides eligible acute care hospitals with funding to complete independent financial and operational audits and to implement recommendations from the audits. The audits and resulting projects focus on enhancing sustainability and efficiency and improving or continuing health care services that benefit the uninsured, underinsured, and MassHealth populations. Final reports for ICB Round 2 grants are due July 31, 2018.

For SFY 2018, the State is providing another opportunity for ICB Round 2. In Q3, the State updated its guidance alerting providers to an additional $10.385M available for eligible acute care hospitals. As in SFY 2017, the funds must be used complete independent financial and operational audits and to implement recommendations from the audits. The audits and resulting projects focus on enhancing sustainability and efficiency and improving or continuing health care services that benefit the uninsured, underinsured, and MassHealth populations. Those eligible hospitals looking to participate in ICB Round 2 were required to submit an attestation in April 2018.

Operational/Issues

During this quarter, MassHealth continued to work with the Massachusetts Health Connector and our systems integration vendor on fixing HIX defects to improve system stability and eliminate workaround processes. These enhancements included a Back Office redesign to improve navigation and information available to eligibility staff to support customer service inquiries, a link with the MH document management system to identify when a document is received to ensure a member is not closed for failure to respond to a request for information/renewal if they have responded prior to the time clock expiration, and defect fixes.

As noted above, during this quarter, MassHealth Operations also continued to support PCDI/ACO implementation by holding several enrollment events to assist members with the transition to new managed care options effective 3/1/2018.

Policy Developments/Issues

During the quarter, EOHHS and CMS continued discussions about the effective date for the provisional eligibility request included in the amendment that EOHHS submitted to CMS on June 26, 2017 and that CMS approved on December 14, 2017. The approved amendment, once implemented, will eliminate provisional eligibility for certain adults.

During the quarter, EOHHS and CMS also continued discussions about the requests included in the amendment that EOHHS submitted to CMS on September 8, 2017. This amendment requests flexibilities to ensure the sustainability of the MassHealth program while retaining access to care for vulnerable populations. The specific requests in the amendment would allow MassHealth to

align coverage for certain non-disabled adults with commercial plans, to adopt widely-used commercial tools to obtain lower drug prices and enhanced rebates, to allow Gold Star veterans and families to continue to have access to health insurance despite the receipt of a state veterans annuity and to improve care, reduce costs and achieve administrative efficiencies through a variety of strategies.

Finally, during the quarter, EOHHS also continued conversations with the state legislature to request support for the items in the amendment that require legislation to implement. Certain items were included in the Governor's FY2019 Budget which was released on January 24, 2018.

Financial/Budget Neutrality Development/Issues

The attached budget neutrality (BN) statement includes actual expenditures and member months through Quarter 3 of state fiscal year (SFY) 2018 as reported through the quarter ending March 31, 2018 (QE 03/31/18). SFY 2018 expenditures and member months are projected from SFY 2018 Quarters 1, 2, and 3 actual data. These data are combined with the MassHealth budget forecast as of March 31, 2018 for SFY 2018-2019 and Commonwealth Care and Health Safety Net (HSN) information provided by the state agencies that manage those programs.

This BN demonstration includes actual expenditure figures, updated according to the most recent complete data available for SFY 2016, SFY 2017, and SFY 2018 Quarters 1, 2, and 3. The enrollment data for the years SFY 2016, SFY2017, and SFY 2018 Quarters 1, 2 and 3 were updated based on actual enrollment through May 2018.

Safety Net Care Pool (SNCP)

The five-year SNCP target is based on projected expenditures for SFY 2018-2022. The changes for SFY 2018 will continue to be updated as the fiscal year progresses.

Budget neutrality - summary

In sum, the total projected budget neutrality cushion is $5.7 billion for the period SFY 2018 through SFY 2022 and $29.7 billion for the period SFY 2012 through SFY 2022. We will continue to update CMS through quarterly reports as updated information is available.

Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Expenditure and Eligibility Group (EG) Reporting	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Base Families	763,641	761,345	754,631	2,279,617
Base Disabled	238,713	238,462	237,294	714,469
1902(r)(2) Children	16,232	15,993	15,907	48,132

1902(r)(2) Disabled	18,900	18,145	17,830	54,875
New Adult Group	352,047	352,685	348,310	1,053,042
BCCDP	1,253	1,265	1,259	3,777
CommonHealth	27,816	28,029	28,264	84,109
TANF/EAEDC*	63,985	64,107	64,194	192,286

*TANF/EAEDC is a subcategory of Base Families

B. For Informational Purposes Only

Expenditure and Eligibility Group (EG) Reporting	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
e-HIV/FA	656	665	674	1,995
Small Business Employee Premium Assistance	22	22	22	66
DSHP- Health Connector Subsidies	N/A	N/A	N/A	N/A
Base Fam XXI RO	0	0	0	0
1902(r)(2) RO	0	0	0	0
CommonHealth XXI	0	0	0	0
Fam Assist XXI	0	0	0	0

Consumer Issues

MassHealth In-Person Enrollment Events

From January through March 2018 we conducted eight events in the cities of Boston (twice at the State Transportation Building), Fall River (Bristol Community College), Lawrence (the Lawrence Public Library), Chicopee (Castle of Knights), Pittsfield (Crowne Plaza Holiday Inn), and Worcester (the DCU Center).

Quality Assurance/Monitoring Activity

Managed Care Quality Activities

In Quarter 3 the MassHealth Managed Care (MCO) Program engaged in several quality activities. Managed Care entities embarked on the collection of HEDIS data for the 2018 HEDIS cycle, which reviews CY17 services. HEDIS data collection will continue into Q4, ending in mid-June with submission to NCQA via the Interactive Data Submission System (IDSS). Post submission to NCQA, MCOs will submit a copy of their IDSS to the MassHealth Quality Office (MQO) for review. Data analysis will begin in Q1 of the next fiscal year; however benchmark data will not be available until Q2.

The MassHealth managed care program modified the Appendix B, Quality Goals Program, of the MassHealth MCO contract. Modifications to the Appendix B consisted of identifying key performance measures by which MCO performance will be assessed annually. Additionally the

modified Appendix B presented updated domains in which the MCOs will be expected to conduct quality improvement projects/activities in the upcoming quality goals cycle.

Finally, EQR activities continued during this quarter. Technical Reports for MCOs were finalized in Q3.

External Quality Review Activities

During this quarter, the EQRO finalized the calendar year 2017 technical reports. The EQRO also continued its planning for the 2018 EQR cycle, completing its work plan as well as PIP reporting templates and guidance. A training was held in March for MCEs regarding performance improvement project reporting. SCOs, MBHP and OneCare plans submitted project plans in March for review and approval by the EQRO. Following approval, MCEs began implementation of Year 1 project activities.

MassHealth Quality Committee

In Quarter 3, the MassHealth Quality Committee continued to meet monthly with representation from various MassHealth programs (e.g., MCO, PCC, ACO, Hospital Incentive and P4P Programs). During this quarter, the Committee focused its effort on identifying performance measure slates to meet the CMS Managed Care Rule requirements for public reporting, specific measures to be included, reporting format, and location on MassHealth website. The Quality Committee continues to review and refine the MassHealth Quality Strategy with the intention of completing it in Q4 for submission to CMS in July.

MassHealth ACO/CP Quality Strategy

In Quarter 3, MassHealth released final specifications of quality measures for the 2018 ACO program with CMS. MassHealth and CMS continue to meet regularly to finalize quality measure benchmarks for the quality measures entering performance in 2019. MassHealth has continued regular discussions with external and internal quality stakeholders, including the procured DSRIP Quality Subcommittee (DSRIP QSC) on issues related to member experience surveys, future measurement priorities, and risk-adjustment. In Quarter 3, MassHealth continued reviewing the technical specifications for the CP quality measure slate with CMS, and continues to work towards finalization of the measures. MassHealth continues actively participating in the DSRIP Quality Measurement Alignment Taskforce, alongside representatives from commercial health insurers, consumers, providers, and purchasers. The DSRIP Quality Measurement Alignment Taskforce aims towards harmonizing quality measures used in ACO quality contracts across the Commonwealth, and striving towards attaining alignment and administrative simplification. In Quarter 3, the DSRIP Quality Measurement Alignment Task Force completed reviewing all candidate measures.

CMS Grant Activities -- Contraceptive Use Grant

During this quarter, the grant team completed and disseminated reports on contraceptive use for dates of service in SFY2017 to 15 Title X funded providers, who had previously received reports

on contraceptive use for dates for dates of service in CY2016. The goal of these reports is to allow providers to identify variations in contraceptive use rates among Title X funded providers, and over time, as a way to support identification of areas for improvement.

The grant team also submitted rates for the Contraceptive Care for Women and the Contraceptive Care Postpartum measures to CMS as part of MIHI and Child and Adult Core Measures set reporting.

Demonstration Evaluation

MassHealth received feedback on its draft overall evaluation design for the 1115 Extension in January 2018 and is working to address CMS' comments. During this quarter, MassHealth requested that the DSRIP Evaluation and the overall 1115 Demonstration Evaluation be combined into one deliverable and aligned the due dates for the two evaluations in order to clarify the evaluations' purpose and reduce unnecessary duplication in evaluation efforts. The Independent Evaluator, the University of Massachusetts Medical School (UMMS), continues to identify data flows necessary to support the evaluation and to develop the design proposal for the DSRIP and overall 1115 Demonstration evaluation due to CMS on the new date of June 30, 2018.

Enclosures/Attachments

In addition to this narrative report, we are submitting:

- Budget Neutrality Workbook
- 5 Zip Files containing the Preliminary DSRIP Participation Plans and Budgets for the CPs and CSAs

State Contact(s)

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Date Submitted to CMS

May 31, 2018

Federal Budget Neutrality Summary

SUBJECT TO PUBLIC COMMENT PROCESS

Room Under the Budget Neutrality Cap				**$ 29,669,916,413**

	Total				
State Fiscal Year	Date of Service Budget Neutrality Ceiling*	CMS 64 Waiver Date of Service Expenditures	BN Savings Phase-Down	SNCP Expenditures	Variance
Fourth Waiver Extension Period					
SFY12 Actual	$ 9,367,766,216	$ 6,119,516,134		$ 1,387,797,555	$ 1,860,452,527
SFY13 Actual	$ 10,066,274,983	$ 6,124,164,549		$ 1,466,434,038	$ 2,475,676,396
SFY14 Actual	$ 11,292,578,515	$ 6,776,211,712		$ 1,475,841,867	$ 3,040,524,937
SFY12-14 SNCP					$ -
	$ 30,726,619,715	**$ 19,019,892,395**		**$ 4,330,073,459**	**$ 7,376,653,860**
Fifth Waiver Extension Period					
SFY15 Actual	$ 13,372,917,802	$ 7,041,818,893		$ 1,958,533,333	$ 4,372,565,575
SFY16 Actual	$ 14,760,483,801	$ 7,789,380,467		$ 1,293,200,000	$ 5,677,903,334
SFY17 Actual	$ 15,585,692,829	$ 7,784,799,335		$ 1,265,700,000	$ 6,535,193,494
SFY15-17 SNCP					$ -
	$ 43,719,094,432	**$ 22,615,998,695**		**$ 4,517,433,333**	**$ 16,585,662,403**
Sixth Waiver Extension Period					
SFY18 Partial Projection	$ 15,554,343,274	$ 7,611,534,243	$ 5,638,821,902	$ 1,909,360,000	$ 394,627,128
SFY19 Projected	$ 16,474,279,130	$ 7,960,800,253	$ 6,130,586,711	$ 1,758,318,447	$ 624,573,720
SFY20 Projected	$ 18,553,421,043	$ 8,241,106,010	$ 7,438,261,046	$ 1,620,458,413	$ 1,253,595,575
SFY21 Projected	$ 19,846,483,134	$ 8,571,841,564	$ 8,154,406,880	$ 1,579,157,788	$ 1,541,076,902
SFY22 Projected	$ 21,267,690,659	$ 8,916,354,793	$ 8,940,772,115	$ 1,516,836,925	$ 1,893,726,825
SFY18-22 SNCP					$ -
	$ 91,696,217,240	**$ 41,301,636,863**	**$ 36,302,848,654**	**$ 8,384,131,573**	**$ 5,707,600,150**
Total	**$ 166,141,931,387**	**$ 82,937,527,954**	**$ 36,302,848,654**	**$ 17,231,638,366**	**$ 29,669,916,413**

* Calculation will vary based on annual Federal DSH Allotment

Federal Budget Neutrality - Cap

			ACA Changes 1/1/14									
TOTAL EXPENDITURES WITH DSH	**$ 9,367,766,216**	**$ 10,066,274,983**	**$ 11,292,578,515**		**$ 13,372,917,802**	**$ 14,760,483,801**	**$ 15,585,692,829**	**$ 15,554,343,274**	**$ 16,474,279,130**	**$ 18,553,421,043**	**$ 19,846,483,134**	**$ 21,267,690,659**
in Waiver, not in S-CHIP												
	Total WY15-SFY12	**Total WY16-SFY13**	**Total WY17-SFY14 Q1&Q2**	**Total WY17-SFY14 Q3&Q4**	**Total WY18-SFY15**	**Total WY19-SFY16**	**Total WY20-SFY17**	**Total WY21-SFY18**	**Total WY22-SFY19**	**Total WY22-SFY20**	**Total WY22-SFY21**	**Total WY23-SFY22**	
MEMBER MONTHS													
				Full year WY17-SFY14									
Base Populations Member Months (1)	*actual*	*actual*		*actual*	*actual*	*actual*	*actual*	*partial projection*	*projected*	*projected*	*projected*	*projected*	MM growth rate:
Families (4)	7,980,378	8,209,463		8,339,714	9,304,426	9,977,195	9,963,122	9,743,977	10,016,808	10,297,279	10,585,603	10,882,000	2.8%
Disabled (3)	2,814,110	2,900,636		2,921,439	2,930,234	2,911,229	2,919,872	2,863,074	2,943,240	3,025,651	3,110,369	3,197,459	2.8%
MCB	-	-		-	-	-	-	-	-	-	-	-	
Total Base	10,794,488	11,110,098		11,261,153	12,234,660	12,888,424	12,882,994	12,607,051	12,960,048	13,322,930	13,695,972	14,079,459	
1902(r)(2) Expansion Member Months (2)	*actual*	*actual*		*actual*	*actual*	*actual*	*actual*	*partial projection*	*projected*	*projected*	*projected*	*projected*	
Kids (1)	112,645	110,899		117,346	169,317	290,455	372,120	215,965	222,012	228,228	234,618	241,187	2.8%
Disabled (2)	184,855	188,777		204,066	222,724	252,518	252,483	227,416	233,784	240,330	247,059	253,977	2.8%
Breast and Cervical Cancer Treatment Program (8)	4,593	4,385		4,066	6,538	12,244	14,086	14,787	15,201	15,627	16,065	16,515	2.8%
Total 1902(r)(2)	302,093	304,060		325,478	398,579	555,217	638,689	458,168	470,997	484,185	497,742	511,679	
				actual	*actual*	*actual*	*actual*	*partial projection*	*projected*	*projected*	*projected*	*projected*	
Category 8 (new population-was Hypothetical)				1,720,774	3,967,240	4,302,083	4,361,917	4,091,719	4,206,287	4,324,063	4,445,137	4,569,601	2.8%
Total Waiver Member Months	11,096,582	11,414,159		13,307,405	16,600,479	17,745,724	17,883,600	17,156,938	17,637,332	18,131,178	18,638,851	19,160,739	2.8%
PER MEMBER PER MONTH COSTS (PMPM)													
Base Population PMPM													
Families	$ 562.02	$ 591.81		$ 623.17	*$ 655.57*	*$ 689.66*	*$ 725.53*	*$ 753.10*	*$ 781.72*	*$ 821.57*	*$ 854.31*	*$ 888.59*	
Disabled	$ 1,224.88	$ 1,298.38		$ 1,376.28	*$ 1,442.34*	*$ 1,511.57*	*$ 1,584.13*	*$ 1,647.49*	*$ 1,713.39*	*$ 2,087.52*	*$ 2,204.44*	*$ 2,331.02*	
MCB													
1902(r)(2) Population PMPM													
Kids	$ 457.59	$ 480.02		$ 503.54	*$ 526.70*	*$ 550.93*	*$ 576.27*	*$ 597.02*	*$ 618.51*	*$ 655.14*	*$ 680.85*	*$ 707.87*	
Disabled	$ 959.04	$ 1,016.59		$ 1,077.58	*$ 1,129.30*	*$ 1,183.51*	*$ 1,240.32*	*$ 1,284.97*	*$ 1,331.23*	*$ 1,387.39*	*$ 1,437.04*	*$ 1,488.48*	
Breast and Cervical Cancer Treatment Program	$ 3,674.67	$ 3,869.43		$ 4,074.51	*$ 4,290.46*	*$ 4,517.85*	*$ 4,757.30*	*$ 4,928.56*	*$ 5,105.99*	*$ 5,324.13*	*$ 5,518.08*	*$ 5,719.25*	
Category 8 (new population-Hypothetical)				*$ 461.23*	*$ 485.67*	*$ 511.42*	*$ 538.52*	*$ 561.68*	*$ 585.83*	*$ 618.02*	*$ 645.01*	*$ 673.21*	
TOTAL EXPENDITURES (Member Months x PMPM)													
Base Population Expenditures													
Families	$ 4,485,132,071	$ 4,858,442,008		$ 5,197,059,780	*$ 6,099,747,586*	*$ 6,880,919,513*	*$ 7,228,516,982*	*$ 7,338,163,111*	*$ 7,830,289,404*	*$ 8,459,937,620*	*$ 9,043,430,671*	*$ 9,669,634,545*	
Disabled/MCB	$ 3,446,947,506	$ 3,766,127,740		$ 4,020,717,649	*$ 4,226,397,927*	*$ 4,400,537,567*	*$ 4,625,455,000*	*$ 4,716,898,805*	*$ 5,042,930,727*	*$ 6,316,107,287*	*$ 6,856,613,462*	*$ 7,453,326,807*	
1902(r)(2) Population Expenditures													
Kids	$ 51,545,264	$ 53,233,562		$ 59,088,401	*$ 89,179,745*	*$ 160,020,713*	*$ 214,443,083*	*$ 128,935,396*	*$ 137,317,216*	*$ 149,521,072*	*$ 159,738,981*	*$ 170,727,975*	
Disabled	$ 177,283,342	$ 191,909,072		$ 219,897,337	*$ 251,523,068*	*$ 298,857,685*	*$ 313,159,443*	*$ 292,222,830*	*$ 311,220,120*	*$ 333,432,303*	*$ 355,034,438*	*$ 378,039,695*	
Breast and Cervical Cancer Treatment Program	$ 16,879,239	$ 16,965,651		$ 16,567,294	*$ 28,051,021*	*$ 55,316,597*	*$ 67,011,322*	*$ 72,878,652*	*$ 77,616,163*	*$ 83,200,121*	*$ 88,647,944*	*$ 94,453,379*	
Category 8 (New Adult population)				$ 793,671,386	$ 1,926,787,558	$ 2,200,151,138	$ 2,348,980,973	$ 2,298,223,234	$ 2,464,164,067	$ 2,672,354,988	$ 2,867,172,372	$ 3,076,286,856	
Total Base + 1902 (r)(2) Expenditures + Benchmarks	**$ 8,177,787,423**	**$ 8,886,678,034**		**$ 10,307,001,847**	**$ 12,621,686,906**	**$ 13,995,803,212**	**$ 14,797,566,803**	**$ 14,847,322,028**	**$ 15,863,537,697**	**$ 18,014,553,391**	**$ 19,370,637,868**	**$ 20,842,469,258**	
Hypothetical Population Expenditures			WY17-SFY14 Q1&Q2	WY17-SFY14 Q3&Q4									
CommonHealth hypothetical (including 65+)	$ 79,202,469	$ 83,910,244	$ 43,640,319	$ 43,640,319	$ 92,228,729	$ 101,585,056	$ 120,055,044	$ 125,337,466	$ 130,852,314	$ 142,959,129	$ 149,220,735	$ 155,756,162	
CommCare Parents hypothetical	$ 43,815,208	$ 42,057,862	$ 31,002,402										
Essential 19-20 hypothetical	$ 26,479,824	$ 27,288,877	$ 13,832,815										
CommCare 19-20 hypothetical	$ 28,367,949	$ 24,914,545	$ 12,943,670.00										
CommCare <133% FPL hypothetical	$ 387,422,325	$ 363,321,426	$ 191,892,964.00										
CommonHealth Medicare Cost Sharing					$337,358	$347,479	$357,904	$368,641	$379,700	$391,091	$402,824	$414,908	
TANF/EAEDC					$375,057,712	$308,219,293	$260,672,056	$262,302,535	$272,270,031	$285,883,533	$300,177,710	$315,186,596	
			Hypotheticals Q1&Q2	*+ Hypotheticals Q3&Q4*									
Total Base + 1902 (r)(2) + hypotheticals	**$ 8,743,075,198**	**$ 9,428,170,988**	**$ 293,312,170**	**$ 10,350,642,165**	**$ 12,713,915,635**	**$ 14,097,388,268**	**$ 14,917,621,846**	**$ 14,972,659,493**	**$ 15,994,390,011**	**$ 18,157,512,520**	**$ 19,519,858,603**	**$ 20,998,225,420**	
				Full year WY17-SFY14									

	Total WY15-SFY12	Total WY16-SFY13	Total WY17-SFY14 Q1&Q2	Total Y17-SFY14 Q3&Q4	Total WY18-SFY15	Total WY19-SFY16	Total WY20-SFY17	Total WY21-SFY18	Total WY22-SFY19	Total WY22-SFY20	Total WY22-SFY21	Total WY23-SFY22
DSH	$ 624,691,018	$ 638,103,995		$ 648,624,180	$ 659,002,167	$ 663,095,533	$ 668,070,983	$ 581,683,781	$ 479,889,119	$ 395,908,523	$ 326,624,532	$ 269,465,239
TOTAL EXPENDITURES WITH DSH*	**$ 9,367,766,216**	**$ 10,066,274,983**		**$ 11,292,578,515**	**$ 13,372,917,802**	**$ 14,760,483,801**	**$ 15,585,692,829**	**$ 15,554,343,274**	**$ 16,474,279,130**	**$ 18,553,421,043**	**$ 19,846,483,134**	**$ 21,267,690,659**

With Waiver Non-SNCP Expenditures

Based on WY 19 expenditures reported on CMS-64.9W as of Period Ended 9/30/16
Combines Medical and LTSS spending

					ACA Changes Take Effect (1/1/2014)						<<<based on actuals	based on forecast>>>			
	MEGs	**WY15-SFY2012**	**WY16-SFY2013**	**FY14 whole**	**WY17-SFY2014 Q1&Q2**	**WY17-SFY2014 Q3&Q4**	**WY18-SFY2015**	**WY19-SFY2016**	**WY20-SFY2017**	**WY21-SFY2018**	**WY22-SFY2019**	**WY23-SFY2020**	**WY24-SFY2021**	**WY25-SFY2022**	**projected growth %**
(1)	1902 (r) (2) Children	$ 55,564,358	$ 58,447,941	$ 63,780,279	$ 31,890,140	$ 31,890,140	$ 95,018,196	$ 117,718,271	$ 141,168,097	$ 98,733,115	$ 102,287,507	$ 105,969,857	$ 109,784,772	$ 113,737,024	3.6%
(2)	1902 (r) (2) Disabled	$ 20,787,513	$ 21,635,867	$ 19,973,113	$ 9,986,556	$ 9,986,556	$ 46,431,794	$ 53,893,665	$ 58,059,406	$ 48,809,969	$ 50,567,128	$ 52,387,545	$ 54,273,497	$ 56,227,343	3.6%
(3)	Base Disabled (includes Base MCB)	$ 1,247,702,158	$ 1,304,448,862	$ 1,250,131,167	$ 625,065,583	$ 625,065,583	$ 2,440,210,573	$ 2,410,255,712	$ 2,430,795,063	$ 2,357,721,502	$ 2,452,037,443	$ 2,550,122,471	$ 2,652,131,041	$ 2,758,220,101	4.0%
(4)	Base Families	$ 2,294,757,881	$ 2,325,904,776	$ 2,296,444,416	$ 1,148,222,208	$ 1,148,222,208	$ 2,551,603,357	$ 2,659,613,103	$ 2,589,753,281	$ 2,517,858,584	$ 2,612,547,846	$ 2,707,530,816	$ 2,805,921,131	$ 2,907,838,647	3.8%
(5)	E - Family Assistance	$ -	$ -	$ -	$ -	0	0	0	0	0	0				
(6)	E - HIV/FA	$ 24,530,454	$ 26,236,814	$ 17,776,664	$ 8,888,332	$ 8,888,332	$ 8,063,606	$ 7,691,898	$ 8,141,271	$ 8,451,952	$ 8,756,222	$ 9,081,857	$ 9,408,804	$ 9,747,521	3.6%
(7)	Basic	$ 166,286,424	$ 163,874,654	$ 70,970,541	$ 70,970,541		0								
(8)	BCCTP	$ 3,921,720	$ 3,593,147	$ 2,803,451	$ 1,401,726	$ 1,401,726	$ 3,874,043	$ 5,412,479	$ 6,837,129	$ 7,546,421	$ 7,818,092	$ 8,506,320	$ 8,812,548	$ 9,129,800	3.6%
(9)	CommonHealth (hypothetical)	$ 79,202,469	$ 83,910,244	$ 87,280,637	$ 43,640,319	$ 43,640,319	$ 92,228,729	$101,585,056	$110,599,176	$103,504,832	$ 107,679,345	$ 118,299,692	$ 123,102,055	$ 128,518,546	4.4%
(10)	Essential	$ 476,422,178	$ 517,418,371	$ 304,271,073	$ 304,271,073										
(11)	Insurance Partnership (IRP)	$ 22,079,592	$ 18,374,800	$ 11,463,694	$ 5,731,847	$ 5,731,847	$ 637,519	$ 206,468	$ 85,521	$ 23,299	0				
(12)	Medical Savings Plan (MSP)	$ 140,022,251	$ 67,599,624	$ 80,718,270	$ 80,718,270		$ 22,177,049								
(13)	Mental Health Special Program for Youth	$ -	$ -	$ -	$ -	0	0	0	0	0	0				
(14)	CommonHealth Medicare Cost Sharing (133%-135% FPL)						$337,358	$347,479	$357,904	$368,641	$379,700	$391,091	$402,824	$414,908	4.4%
(15)	TANF/EAEDC						$375,057,712	$308,219,293	$260,672,056	$262,302,535	$272,270,031	$285,883,533	$300,177,710	$315,186,596	
(16)	SBE						$810,248	0	0	0	0	0	0	0	3.6%
(17)	Duals with no resources test	$ 1,121,947,742	$ 1,109,386,640	$ 1,153,706,129	$ 576,853,065	$ 576,853,065									
(18)	Category 8: New Adult			$ 1,159,088,567		$ 1,147,365,896	$ 1,338,283,602	$ 2,052,658,355	$ 2,056,908,378	$ 2,120,207,888	$ 2,213,497,035	$ 2,310,890,905	$ 2,412,570,105	$ 2,518,723,190	4.4%
(19)	LTSS (all MEGs)														
	Preliminary Total Expenditures	**$ 5,653,224,740**	**$ 5,700,831,740**	**$ 6,518,408,001**	**$ 2,907,639,659**	**$ 3,599,045,671**	**$ 6,974,733,786**	**$ 7,717,601,779**	**$ 7,663,377,282**	**$ 7,525,528,737**	**$ 7,827,840,349**	**$ 8,149,064,087**	**$ 8,476,584,487**	**$ 8,817,743,676**	
	SUD Waiver (net cost)	$ -	$ -						$ 23,000,000	$ 55,167,284	$ 57,539,477	$ 60,013,675	$ 62,594,263	$ 65,285,816	4.3%
	CommonHealth 65+								$ 9,455,868	$ 9,871,926	$ 10,306,291	$ 10,759,767	$ 11,233,197	$ 11,727,458	4.4%
	CommCare Parents hypothetical	$ 42,057,862	$ 31,002,402	$ 15,501,201	$ 15,501,201										
	CommCare 19-20 hypothetical	$ 28,367,949	$ 24,914,545	$ 12,943,670	$ 12,943,670										
	CommCare <133 FPL hypothetical	$ 387,422,325	$ 363,321,426	$ 191,892,964	$ 191,892,964										
	Essential 19-20 hypothetical	$ -	$ -	$ -	$ -	$ -									
	Misc (MH BPHC)	9,121	23	0	0	0	$ -								
	SHIP Continuous Eligibility								$ 1,310,400	$ 3,360,000	$ 3,507,840	$ 3,662,185	$ 3,823,321	$ 3,991,547	4.4%
	PCPR (Primary Care Payment Reform)			$ 15,726,628	$ 7,863,314	$ 7,863,314	$ 47,273,429	$ 52,374,817	$ 67,503,760	$ -	$ -				
	Medical Homes	$ 4,034,137	$ 4,803,119	$ 14,875,139	$ 7,437,570	$ 7,437,570									
	Pediatric Asthma	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Early Intervention Specialty Services	$ 4,400,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Provisional Eligibility			$ 11,000,000		$ 11,000,000	$ 3,545,188	$ 3,545,188	$ 3,545,188	$ 3,545,188	$ 3,545,188	$ 3,545,188	$ 3,545,188	$ 3,545,188	
	Pilot ACO shared savings										44000000				
	End-of-Month Coverage			$ 7,000,000		$ 7,000,000	$ 14,061,108	$ 14,061,108	$ 14,061,108	$ 14,061,108	$ 14,061,108	$ 14,061,108	$ 14,061,108	$ 14,061,108	
	1915(c) adjustment														
	1115A Duals Demonstration Savings		$ (708,706)	$ (11,135,892)			$ 2,205,382.64	$ 1,797,575.00	$ 2,545,729.32						
	Total Projected Expenditures (non-SNCP)	**$ 6,119,516,134**	**$ 6,124,164,549**	**$ 6,776,211,712**	**$ 3,143,278,378**	**$ 3,632,346,555**	**$ 7,041,818,893**	**$ 7,789,380,467**	**$ 7,784,799,335**	**$ 7,611,534,243**	**$ 7,960,800,253**	**$ 8,241,106,010**	**$ 8,571,841,564**	**$ 8,916,354,793**	
	Schedule C Total	**$ 7,472,802,633**	**$ 7,233,371,522**	**$ 7,961,152,443**	**$ 3,980,576,222**	**$ 3,980,576,222**	**$ 8,585,619,430**	**$ 8,806,841,923**	**$ 8,815,428,463**	**$ 8,459,588,321**					
	Exclude Sch. C SNCP expenditures	$ (1,403,778,498)	$ (1,144,303,788)	$ (1,281,545,518)	$ (640,772,759)	$ (640,772,759)	$ (1,610,885,644)	$ (1,089,240,144)	$ (1,152,051,181)	$ (934,059,584)					
	Exclude Sch. C CC Hypo expenditures	$ (415,790,274)	$ (388,235,971)	$ (204,836,634)	$ (204,836,634)	$ -	$ -	$ -	$ -	$ -					
	Exclude Essential 19-20 Hypo expend.	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
	BPHC	$ (9,121)	$ (23)												
	Subtotal: Non-SNCP non-Hypo Sch. C	**$ 5,653,224,740**	**$ 5,700,831,740**	**$ 6,474,770,291**	**$ 3,134,966,829**	**$ 3,339,803,463**	**$ 6,974,733,786**	**$ 7,717,601,779**	**$ 7,663,377,282**	**$ 7,525,528,737**					
	Completion (claims run out)			$ 31,915,039	$ 31,915,039	$ -		$ -							
	Actual / Estimated P4P	$ 43,744,719	$ 37,500,000	$ 28,822,684	$ 14,411,342	$ 14,411,342	$ 31,999,528	$ 28,616,834	$ 21,253,812	$ 21,253,812					
	CarePlus payments to plans			$ 11,722,671											
	Total expenditures not yet reported on Schedule C	**$ -**	**$ -**	**$ 43,637,710**	**$ 31,915,039**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**					
	Total Schedule C with Adjustments	**$ 5,653,224,740**	**$ 5,700,831,740**	**$ 6,518,408,001**	**$ 3,166,881,868**	**$ 3,339,803,463**	**$ 6,974,733,786**	**$ 7,717,601,779**	**$ 7,663,377,282**	**$ 7,525,528,737**					
	Total from above (line 25)	**$ 5,653,224,740**	**$ 5,700,831,740**	**$ 6,518,408,001**	**$ 2,907,639,659**	**$ 3,599,045,671**	**$ 6,974,733,786**	**$ 7,717,601,779**	**$ 7,663,377,282**	**$ 7,525,528,737**					
	Tie out	$ -	$ -	$ (0)	$ 259,242,209	$ (259,242,209)	$ -	$ -	$ -	$ (0.01)					
		0.00%	*0.00%*	*0.00%*			*0.00%*	*0.00%*	*0.00%*	*0.00%*					

Base PMPM

WOW Base PMPMs are trended from existing WOW PMPM using the President's Budget trend rate

1115 Demonstration Renewal (December 2011) trend rate

	SFY 2012	SFY 2013	SFY 2014	
Base Families	5.3%	5.3%	5.3%	Adults + Children trend
Base Disabled/MCB	6.0%	6.0%	6.0%	Blind/Disabled trend
1902 (r) 2 Children	4.9%	4.9%	4.9%	Children trend
1902 (r) 2 Disabled	6.0%	6.0%	6.0%	Blind/Disabled trend
1902 (r) 2 BCCTP	5.3%	5.3%	5.3%	Adults trend

Note: these trends reflect a 2011-2013 aggregate trend (per CMS direction)

Base PMPMs without adjustments

			4th Extension	
	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Base Families	$ 533.73	$ 562.02	$ 591.81	$ 623.17
Base Disabled/MCB	$ 1,155.55	$ 1,224.88	$ 1,298.38	$ 1,376.28
1902 (r) 2 Children	$ 436.22	$ 457.59	$ 480.02	$ 503.54
1902 (r) 2 Disabled	$ 904.76	$ 959.04	$ 1,016.59	$ 1,077.58
1902 (r) 2 BCCTP	$ 3,489.72	$ 3,674.67	$ 3,869.43	$ 4,074.51

Hypothetical Trends				
CommCare & Essential	5.3%	5.3%	5.3%	Adults trend
CommonHealth	6.0%	6.0%	6.0%	Blind/Disabled trend

President's trend:

1115 Demonstration 2016 Renewal trend rate

	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	
Base Families	5.2%	5.2%	5.2%	3.8%	3.8%	3.8%	3.8%	3.8%	Adults + Children trend
Base Disabled/MCB	4.8%	4.8%	4.8%	4.0%	4.0%	4.0%	4.0%	4.0%	Blind/Disabled trend
1902 (r) 2 Children	4.6%	4.6%	4.6%	3.6%	3.6%	3.6%	3.6%	3.6%	Current Children trend
1902 (r) 2 Disabled	4.8%	4.8%	4.8%	3.6%	3.6%	3.6%	3.6%	3.6%	Blind/Disabled trend
1902 (r) 2 BCCTP	5.3%	5.3%	5.3%	3.6%	3.6%	3.6%	3.6%	3.6%	Current Adults trend

Hypothetical Trends

CommCare & Essential	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	Current Adults trend
CommonHealth	4.8%	4.8%	4.8%	4.4%	4.4%	4.4%	4.4%	4.4%	Blind/Disabled trend

Base PMPMs without adjustments

5th Extension

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Base Families	$ 623.17	$ 655.57	$ 689.66	$ 725.53	$ 753.10	$ 781.72	$ 811.42	$ 842.25	$ 874.26
Base Disabled/MCB	$ 1,376.28	$ 1,442.34	$ 1,511.57	$ 1,584.13	$ 1,647.49	$ 1,713.39	$ 1,781.93	$ 1,853.21	$ 1,927.34
1902 (r) 2 Children	$ 503.54	$ 526.70	$ 550.93	$ 576.27	$ 597.02	$ 618.51	$ 640.78	$ 663.85	$ 687.75
1902 (r) 2 Disabled	$ 1,077.58	$ 1,129.30	$ 1,183.51	$ 1,240.32	$ 1,284.97	$ 1,331.23	$ 1,379.15	$ 1,428.80	$ 1,480.24
1902 (r) 2 BCCTP	$ 4,074.51	$ 4,290.46	$ 4,517.85	$ 4,757.30	$ 4,928.56	$ 5,105.99	$ 5,289.81	$ 5,480.24	$ 5,677.53

LTSS PMPM

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Base Families					7.19	8.54	10.15	12.06	14.33
Base Disabled/MCB					231.33	265.88	305.59	351.23	403.68
1902 (r) 2 Children					10.25	12.13	14.36	17.00	20.12
1902 (r) 2 Disabled					8.24	8.24	8.24	8.24	8.24
1902 (r) 2 BCCTP					28.23	31.13	34.32	37.84	41.72

TOTAL PMPM: Medical + LTSS PMPM

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Base Families	$ 623.17	$ 655.57	$ 689.66	$ 725.53	$ 760.29	$ 790.26	$ 821.57	$ 854.31	$ 888.59
Base Disabled/MCB	$ 1,376.28	$ 1,442.34	$ 1,511.57	$ 1,584.13	$ 1,878.82	$ 1,979.27	$ 2,087.52	$ 2,204.44	$ 2,331.02
1902 (r) 2 Children	$ 503.54	$ 526.70	$ 550.93	$ 576.27	$ 607.27	$ 630.64	$ 655.14	$ 680.85	$ 707.87
1902 (r) 2 Disabled	$ 1,077.58	$ 1,129.30	$ 1,183.51	$ 1,240.32	$ 1,293.21	$ 1,339.47	$ 1,387.39	$ 1,437.04	$ 1,488.48
1902 (r) 2 BCCTP	$ 4,074.51	$ 4,290.46	$ 4,517.85	$ 4,757.30	$ 4,956.79	$ 5,137.12	$ 5,324.13	$ 5,518.08	$ 5,719.25

ACA PMPM

		CommCare 19+20
SFY 2009	$	374.33
SFY 2010	$	392.71
SFY 2011	$	338.05
SFY 2012	$	399.63
SFY 2013	$	420.81
SFY 2014	$	443.11

Actual / Projected PMPM		
		CommCare <133 (k)(2)
SFY 2009		N/A
SFY 2010	$	397.48
SFY 2011	$	393.82
SFY 2012	$	407.89
SFY 2013	$	429.51
SFY 2014	$	452.28

Actual / Projected PMPM	
	Essential 19+20
SFY 2009	$292.13
SFY 2010	$311.52
SFY 2011	$271.48
SFY 2012	$297.58
SFY 2013	$313.35
SFY 2014	$329.96

Note: The hypothetical populations to the left are some of the populations that will make up the new "VIII Group" in 2014. The new VIII Group also will include other populations, such as our current Basic and Essential 21-64 year old populations. The Essential population, for example, will make up about one-third of the total VIII Group. Essential members are significantly higher cost (approx. $1,000 PMPM). This will increase the average cost for the overall VIII Group compared to the historical costs for the hypothetical populations shown here. In addition, the benefits and cost sharing

		= (AVG Enrollment / Total Enrollment)	PMPM
CarePlus Direct Coverage RC IX From MassHealth	MassHealth Essential (0 - 100%)	33.97%	445
	MassHealth HIV (0 - 138%)	0.00%	445
	Insurance Partnership (0- 138%)	0.34%	445
From CommCare	CommCare (0 - 100%)	21.89%	445
	CommCare Adults (101 - 138%)	9.04%	445
From HSN	HSN (0 - 100%)	3.34%	445
	HSN (101 - 138%)	0.86%	445
From MSP	MSP - Premium Assistance (0 - 100%)	0.02%	445
	MSP - Direct Coverage (0 - 100%)	0.21%	445
	MSP - Premium Assistance (101 - 138%)	0.05%	445

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	MSP - Direct Coverage (101 - 138%)	0.29%	445
New MassHealth Enrollees	New Adult Enrollees - Childless (0 - 100%)	3.17%	445
	New Adult Enrollees - Childless (101 - 138%)	2.19%	445
CarePlus Direct Coverage RC X	MassHealth Basic 21-64 Yr Olds	4.98%	1075
CarePlus Premium Assistance	Insurance Partnership (0- 138%)	0.34%	349
	HSN (0 - 100%)	5.01%	383
	HSN (101 - 138%)	1.30%	350
	New Adult Enrollees - Childless (0 - 100%)	3.17%	350
	New Adult Enrollees - Childless (101 - 138%)	2.19%	350
Standard/Benchmark 1	MassHealth HIV (0 - 138%)	0.32%	1410
	MassHealth Basic 19-20 Yr Olds	0.04%	322
	MassHealth Essential 19-20 Yr Olds	2.03%	322
	CommCare (0 - 100%) 19-20 Yr Olds	1.32%	322
	CommCare Adults (101 - 138%) 19-20 Yr Olds	0.23%	322
	HSN (0 - 100%)	0.51%	322
	HSN (101 - 138%)	0.06%	322
	MSP - Premium Assistance (0 - 100%)	0.00%	322
	MSP - Direct Coverage (101 - 138%)	0.01%	322
	MSP - Premium Assistance (101 - 138%)	0.00%	322
	MSP - Direct Coverage (101 - 138%)	0.01%	322
	New Adult Enrollees - Parents (0 - 138%)	2.61%	350
	New Adult Enrollees - Childless (0 - 100%) 19-20	0.38%	322
	New Adult Enrollees - Childless (101 - 138%) 19-20	0.11%	322
ACA Expansion Population	**Weighted Average PMPM**	**461.23**	

New Adult Group PMPM without adjustments

			5th Extension							
	SFY 2014		**SFY 2015**	**SFY 2016**	**SFY 2017**	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**
New Adults		$461.23	$485.67	$511.42	$538.52	$561.68	$585.83	$611.02	$637.29	$664.70
	Trend Rate		5.3%	5.3%	5.3%	4.3%	4.3%	4.3%	4.3%	4.3%
	LTSS					5.73	6.32	7.00	7.72	8.51
	Total PMPM		$485.67	$511.42	$538.52	$567.41	$592.15	$618.02	$645.01	$673.21

CommonHealth

1/8/2016

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Trended baseline CommonHealth costs
Base year: SFY 2006
Approved trend rates: 7.0% through SFY 2008, 7.61% through SFY 2011
Using 1115 Demonstration trends for disabled for 2012-2014, 6.0%

4.80% Updated Trend Rate for SFY 15-21
4.40% Updated Trend Rate for SFY 17-22

	SFY 2006
Total spending	$ 61,168,938
Part D spending	$ 8,730,110
Net spending	$ 52,438,828
Member months	137,818
PMPM	$ 380.49

This calculation is based on the same data used for the adjustment from the 2006 amendment

Trend through SFY 2022

	Member Months (not incl. 65+)	Trended PMPM (not incl. 65+)	Trended spending (not incl. 65+)	Member Months (65+)	Trended PMPM (65+)	Trended spending (65+)	LTSS PMPM	LTSS spending (PMPM x MM)	**Total trended spending**
SFY 2006	137,818	$ 380.49	$ 52,438,828						**$ 52,438,828**
SFY 2007	147,218	$ 407.13	$ 59,936,748						**$ 59,936,748**
SFY 2008	157,887	$ 435.63	$ 68,779,809						**$ 68,779,809**
SFY 2009	164,603	$ 465.51	$ 76,624,474						**$ 76,624,474**
SFY 2010	185,138	$ 497.44	$ 92,095,935						**$ 92,095,935**
SFY 2011	201,460	$ 531.57	$ 107,089,890						**$ 107,089,890**
SFY 2012	214,279	$ 563.46	$ 120,737,583						**$ 120,737,583**
SFY 2013	216,304	$ 609.43	$ 131,821,823						**$ 131,821,823**
SFY 2014	223,704	$ 643.37	$ 143,923,930						**$ 143,923,930**
SFY 2015	229,545	$ 674.25	$ 154,770,582						**$ 154,770,582**
SFY 2016	236,432	$ 706.61	$ 167,065,908						**$ 167,065,908**
SFY 2017	243,525	$ 737.70	$ 179,649,342	28,072	$ 381.08	$ 10,697,678			**$ 190,347,019**
SFY 2018	250,831	$ 770.16	$ 193,180,723	28,072	$ 397.85	$ 11,168,445			**$ 204,349,168**
SFY 2019	258,356	$ 804.05	$ 207,731,151	28,072	$ 415.36	$ 11,659,986			**$ 219,391,137**
SFY 2020	266,107	$ 839.43	$ 223,377,730	28,072	$ 433.64	$ 12,173,142	$ 23.86	$ 6,349,313	**$ 241,900,185**
SFY 2021	274,090	$ 876.36	$ 240,202,356	28,072	$ 452.72	$ 12,708,756	$ 24.08	$ 6,600,087	**$ 259,511,199**
SFY 2022	282,313	$ 914.92	$ 258,294,672	28,072	$ 472.64	$ 13,267,950	$ 24.30	$ 6,860,206	**$ 278,422,828**

Updated trend

Actuals (with projections)

From WW Expenditures

Used for WOW Cap

	Member Months (not incl. 65+)	Trended PMPM (not incl. 65+)	Trended spending (not incl. 65+)	Member Months (65+)	Trended PMPM (65+)	Trended spending (65+)	LTSS PMPM	LTSS spending (PMPM x MM)	**Actual / projected spending**	**Lesser of Actuals or Trended**
SFY 2015	267,769	$ 344.43	$ 92,228,729						**$ 92,228,729**	**$ 92,228,729**
SFY 2016	292,615	$ 347.16	$ 101,585,056						**$ 101,585,056**	**$ 101,585,056**
SFY 2017	301,477	$ 366.86	$ 110,599,176	25,813	$ 366.32	$ 9,455,868			**$ 120,055,044**	**$ 120,055,044**
SFY 2018	310,522	$ 371.84	$ 115,465,540	26,588	$ 371.29	$ 9,871,926			**$ 125,337,466**	**$ 125,337,466**
SFY 2019	319,838	$ 376.90	$ 120,546,023	27,386	$ 376.33	$ 10,306,291			**$ 130,852,314**	**$ 130,852,314**
SFY 2020	329,433	$ 382.02	$ 125,850,049	28,208	$ 381.44	$ 10,759,767	$ 23.86	$ 6,349,313	**$ 142,959,129**	**$ 142,959,129**
SFY 2021	339,316	$ 387.21	$ 131,387,451	29,054	$ 386.63	$ 11,233,197	$ 24.08	$ 6,600,087	**$ 149,220,735**	**$ 149,220,735**
SFY 2022	349,495	$ 392.48	$ 137,168,498	29,926	$ 391.88	$ 11,727,458	$ 24.30	$ 6,860,206	**$ 155,756,162**	**$ 155,756,162**

SFY15 CH working adults 65+ values (2/22/16)

Member months	28,072
PMPM	$ 348.30
spending	$ 9,777,406

<65 MM trend rate

1.03
1.03
1.03
1.03 rate to use

SFY17 CH working adults 65+ values (11/16/16)

Member months	42,124
PMPM	$ 366.32
Spending	$ 15,430,892

Medicare Cost Sharing for CommonHealth Population between 133-135% FPL

133-135% FPL	Medicare Cost Sharing - CommonHealth Population		
	Member Months	PMPM	Total Projected Expenditures
SFY 2015	3,216	$104.90	$337,358
SFY 2016	3,264	$106.45	$347,479
SFY 2017	3,313	$108.02	$357,904
SFY 2018	3,363	$109.62	$368,641
SFY 2019	3,413	$111.24	$379,700
SFY 2020	3,465	$112.88	$391,091
SFY 2021	3,517	$114.55	$402,824
SFY 2022	3,569	$116.24	$414,908

EAEDC and TANF PMPM Projection

	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Member Months	1,141,320	904,203	761,602	770,999	792,587	814,779	837,593	861,046
Amount Paid	$375,057,711.56	$308,219,293.37	$260,672,056.05	$262,302,534.95	$272,270,031.27	$285,883,533	$300,177,710	$315,186,596
PMPM	$328.62	$340.87	$342.27	$340.21	$343.52	$350.87	$358.38	$366.05

Member Months Trend
2.8%

1115 Demonstration 2014 Renewal (June 2014) trend rate				1115 Demonstration 2017 Renewal trend rate						
	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022		
Base Families	5.2%	5.2%	5.2%	3.8%	3.8%	3.8%	3.8%	3.8%	Adults + Children trend	Updated
Base Disabled/MCB	4.8%	4.8%	4.8%	4.0%	4.0%	4.0%	4.0%	4.0%	Blind/Disabled trend	Updated
1902 (r) 2 Children	4.6%	4.6%	4.6%	3.6%	3.6%	3.6%	3.6%	3.6%	Current Children trend	Updated
1902 (r) 2 Disabled	4.8%	4.8%	4.8%	3.6%	3.6%	3.6%	3.6%	3.6%	Blind/Disabled trend	Updated
1902 (r) 2 BCCTP	5.3%	5.3%	5.3%	3.6%	3.6%	3.6%	3.6%	3.6%	Current Adults trend	Updated
Hypothetical Trends										
CommCare & Essential	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	Current Adults trend	no longer exists
CommonHealth	4.8%	4.8%	4.8%	4.4%	4.4%	4.4%	4.4%	4.4%	Blind/Disabled trend	Updated

MA SUD PMPM Back-Up

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11/4/2016

Service Type	User Months	Total Spend SFY18
Residential Rehab Services		
Adult	81,242	$ 31,511,896
Youth	2,355	$ 913,598
Adolescent	2,673	$ 1,036,893
Family	2,627	$ 1,018,836
Transitional Support Services	53,332	$ 20,686,061
Total	**142,230**	**$ 55,167,284**

Updated 5/31/2017

Service Type	User Months	Total Spend SFY17
Residential Rehab Services		
Adult	33,871	$ 13,137,743
Youth	982	$ 380,892
Adolescent	1,115	$ 432,295
Family	1,095	$ 424,767
Transitional Support Services	22,234	$ 8,624,304
Total	**59,297**	**$ 23,000,000**

SHIP PMPM

Continuous Eligibility spending only

Based on estimated premium contribution and enrollment

		SFY17	SFY18&19	Notes
		7,800	20,000	Total SHIP members with MH Premium Assistance: July to July
Estimated PMPM	**$ 300**	5,200	13,333	Members with alternate redetermination period (66%)
		1,248	**3,200**	Members who would have otherwise closed (24%)

Month	Alt. Redet. Multiplier	SFY17	**Cost SFY17**	SFY18&19	**Cost SFY18**	**Cost SFY19**	
Jan	6	208	$ 374,400	533	$ 960,000	$ 960,000	
Feb	5	208	$ 312,000	533	$ 800,000	$ 800,000	
March	4	208	$ 249,600	533	$ 640,000	$ 640,000	
April	3	208	$ 187,200	533	$ 480,000	$ 480,000	
May	2	208	$ 124,800	533	$ 320,000	$ 320,000	
June	1	208	$ 62,400	533	$ 160,000	$ 160,000	
			$ 1,310,400		**$ 3,360,000**	**$ 3,360,000**	**Annual Cost for Continuous Eligibility**

ACO Shared Savings

Member Months	PMPM	Total Spend SFY19
1,200,000	$ 36.67	$ 44,000,000

A.	B.	C.	D.	E.	F.	G.
1115A Duals Demo Rate Year/ Demo Year	**MassHealth Component of the Capitation Rate (hypothetical)**	**Medicaid Savings Percentage Applied Per Contract (average)**	**Savings Per Month: (B*C)**	**Member Months of MMEs who participated in 1115A Duals Demonstration and 1115(a) Demonstration (hypothetical)**	**Risk Corridor Payment/ (Recoupment)1**	**Amount subtracted from 1115(a) BN savings/ margin: (D*E)-F = net (cost)/savings**
CY 2013/ DY1 (October-December)	$ 691.12	0%	$ -	10,218.74	$ 708,706.31	$ (708,706.31)
CY 2014 (Jan - Mar 2014)/ DY1	$ 597.11	0%	$ -	27,962.96	$ 1,939,331.64	$ (1,939,331.64)
CY 2014 (Apr - Dec 2014)/ DY1	$ 702.57	1%	$ 7.03	147,551.28	$ 10,233,211.05	$ (9,196,560.05)
Fallon Total Care (FTC) CY 2015/ DY2	$ 569.10	1.50%	$ 8.54	47,772.23		$ 407,807.64
CCA and Tufts CY 2015/ DY2	$ 1,138.50	0%	$ -	144,175.89	$ (1,797,575.00)	$ 1,797,575.00
CY 2016/ DY3	$ 1,482.23	0%	$ -	152,730.15	$ (1,797,575.00)	$ 1,797,575.00
CY 2017/ DY4	$ 1,491.71	0.25%	$ 3.73	200,616.56	$ (1,797,575.00)	$ 2,545,729.32
CY 2018/ DY5		0.50%	$ -			$ -

For CY 2016 and CY 2017, the risk corridor/recoupment amounts are not available, so the CY 2015 value is being used.

Projected DSH allotment

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FFY	Allot W/O ARRA (Federal share)	Allot W/ ARRA (Federal share)	CMS Corrections *	*11/1/16 MassHealth Edits*	Allotment w/ ARRA (Total Computable)	*11/1/16 MassHealth Edits*	Source	CMS Corrections	Source
2008	287,285,600				574,571,200	***574,571,200***	Federal Register		Federal Register
2009	299,926,166	307,424,320	307,424,320	***307,424,320***	614,848,640	***614,848,640***	Federal Register		Federal Register
2010	299,926,166	315,109,928	315,109,928	***315,109,928***	630,219,856	***630,219,856***	Federal Register		Federal Register
2011	305,324,837		305,024,911	***305,024,911***	610,649,674	***610,049,822***	Federal Register	610,049,822	Federal Register
2012	314,685,733		312,955,559	***312,955,559***	629,371,466	***625,911,118***	CMS	625,911,118	Federal Register
2013	320,507,419		320,466,492	***320,466,492***	641,014,838.12	***640,932,984***	Projected using CPI-U estima	640,932,984	Federal Register
2014	325,273,489		325,273,489	***325,593,956***	650,546,978.00	***651,187,912***	Federal Register	650,546,978	Federal Register
2015	331,778,959		330,477,865	***330,803,459***	663,557,917.56	***661,606,918***	Federal Register		
2016	273,717,641		337,419,933	***331,795,869***	547,435,281.99	***663,591,738***	Federal Register (Prelim)		
2017	225,817,054		343,662,202	***334,782,032***	451,634,107.64	***669,564,064***	Federal Register (Prelim)		
2018	186,299,069		350,019,952	***276,195,176***	372,598,138.80	***552,390,353***	Projected using estimated MA DSH reduction percentage		
2019	153,696,732		356,495,322	***227,861,021***	307,393,464.51	***455,722,041***	Projected using estimated MA DSH reduction percentage		
2020	126,799,804		356,495,322	***187,985,342***	253,599,608.22	***375,970,684***	Projected using estimated MA DSH reduction percentage		
2021	104,609,838		356,495,322	***155,087,907***	209,219,676.78	***310,175,814***	Projected using estimated MA DSH reduction percentage		
2022	86,303,117		356,495,322	***127,947,523***	172,606,233.35	***255,895,047***	Projected using estimated MA DSH reduction percentage		

Assumptions
CMS' "Corrections" based on guidance effective March 31, 2014
Calculation in reg 42 C.F.R. § 447.294 (effective Nov. 18, 2013, still current)
Updated guidance on reductions was issued April 16, 2015- effective date shifted to FY18, same methdology

Shift to SFY	**(3/4 same SFY; 1/4 next SFY)**	
SFY 2009	$ 604,779,280	
SFY 2010	$ 626,377,052	
SFY 2011	$ 615,542,220	
SFY 2012	$ 624,691,018	
SFY 2013	$ 638,103,995	
SFY 2014	***$ 648,624,180***	
SFY 2015	***$ 659,002,167***	
SFY 2016	***$ 663,095,533***	
SFY 2017	***$ 668,070,983***	Projected decline begins Oct 1, 2017
SFY 2018	***$ 581,683,781***	
SFY 2019	***$ 479,889,119***	
SFY 2020	***$ 395,908,523***	
SFY 2021	***$ 326,624,532***	
SFY 2022	***$ 269,465,239***	

2014 3-year renewal DSH allotment	$ 1,874,073,054	**5-year renewal DSH allotment SFY 18-22**

$ 3,375,000,000 Held flat at $675M/year

Change in SNCP

Base	$ 4,600,000,000	
Old DSH	$ 1,723,713,600	
New DSH	$ 1,874,073,054	*used for SNCP cap and provider subcap*
Change	$ 150,359,454	
New SNCP (SFY 2009 to 2011)	$ 4,750,359,454	

Sources:

FY 2009 Revised Preliminary Allotment U/ARRA
FY 2010 Preliminary Allotment
FY 2014 Final- Federal Register (2016)
FY 2016 Final- Federal Register (2016)

2016: https://www.gpo.gov/fdsys/pkg/FR-2016-10-26/pdf/2016-25813.pdf
2014: https://federalregister.gov/a/2014-04032

2010: http://edocket.access.gpo.gov/2010/pdf/2010-8502.pdf
p. 21314 Federal Register / Vol. 75, No. 78 / Friday, April 23, 2010 / Notices

DSH Allotment prior to FY18 reduction methodology changes
DSH Allotment grows based on CPI-U - Consumer Price Index for all Urban Consumers.

FFY 2014	1.1 to 1.2	1.15%	Core PCE inflation projection
Longer term	2.0	2.00%	PCE inflation projection

Monetary Policy Report to the Congress (February 11, 2014)
http://www.federalreserve.gov/monetarypolicy/mpr_20140211_part3.htm

FFY 2010	0.8 to 1.0	0.90%	Core PCE inflation projection
Longer term	1.7 to 2.0	1.85%	PCE inflation projection

Monetary Policy Report to the Congress (July 21, 2010)
http://www.federalreserve.gov/monetarypolicy/mpr_20100721_part4.htm

DSH Allotment FY18 and after, with reduction applied

Estimated MA reduction %	17.5%	Assumes same percentage reduction is applied year-over-year, beginning FY 2018

http://www.gpo.gov/fdsys/pkg/FR-2014-02-28/pdf/2014-04032.pdf

SNCP

SNCP expenditures for dates of service in SFY 2012-2014 (projected and rounded)									SNCP expenditures for dates of service in SFY 2015-2019 (projected and rounded)					
#	Type	Source of Non-Federal Share	Applic. caps	Eligible providers	Total SNCP expenditure per SFY 12-14			3-year total 12-14	Total SNCP expenditure per SFY 15-19					5-year total 15-19
					SFY 2012	SFY 2013	SFY 2014		SFY2015	SFY2016	SFY2017	SFY2018	SFY2019	
1	Public Service Hospital Safety Net Care Payment	State appropriation	Provider	Boston Medical Center	$ 332.0	$ 332.0	$ 332.0	**$ 996.0**	$ 52.0	$ 52.0	$ 52.0			**$ 156.0**
				Cambridge Health Alliance					$ 88.0	$ 88.0	$ 88.0			**$ 264.0**
2	Health Safety Net Trust Fund Safety Net Care Payment	State appropriation, payer surcharge	Provider	All acute hospitals	$ 77.7	$ 159.4	$ 156.3	**$ 393.4**	$ 169.2	$ 178.0	$ 156.3			**$ 503.50**
3	Institutions for Mental Disease (IMD)	State appropriation	Provider	Psychiatric Inpatient Hospitals Community-based detoxification centers	$ 9.9	$ 22.0	$ 24.0	**$ 55.8**	$ 17.9	$ 35.9	$ 36.7			**$ 90.50**
4	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	CPE	Provider	Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Mass. Hospital	$ 40.0	$ 43.0	$ 45.0	**$ 128.0**	$ 39.5	$ 41.0	$ 51.9			**$ 132.40**
5	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	CPE	Provider	Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Lindemann Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester State Hospital	$ 70.0	$ 74.0	$ 77.0	**$ 221.0**	$ 98.0	$ 108.8	$ 127.1			**$ 333.90**
6	Delivery System Transformation Incentives	State appropriation, IGT	DSTI	Cambridge Health Alliance Boston Medical Center Holyoke Medical Center Lawrence General Hospital Mercy Medical Center Signature Healthcare Brockton Hospital Steward Carney Hospital	$ 209.3	$ 208.4	$ 208.3	**$ 626.0**	$ 209.3	$ 213.8	$ 211.3			**$ 634.43**
7	Public Hospital Incentive Initiative	State appropriation, IGT	n/a	Cambridge Health Alliance					$ 220.0	$ 220.0	$ 220.0			**$ 660.00**
8	Designated State Health Programs (DSHP)	State appropriation	DSHP	n/a	$ 340.9	$ 310.0	$ 130.0	**$ 780.9**	$ 365.7	$ 257.0	$ 123.3			**$ 746.00**
9	DSHP - Connector Care premium subsidies	State appropriation	DSHP (CC Prem Subsidies)	n/a	n/a	n/a	$ -	**$ -**	$ 31.4	$ 98.7	$ 111.0	$ 106.0	$ 111.0	**$ 458.10**
10	DSHP- Connector Care cost sharing subsidies	State appropriation	DSHP (CC Cost Share Subs	n/a	n/a	n/a	n/a	**$ -**	n/a	n/a	$ 62.1	$ 91.9	$ 96.7	**$ 250.70**
11	DSHP - Commonwealth Care Transition	State appropriation	Overall SNCP (CC transition	n/a	n/a	n/a	$ 139.5	**$ 139.5**	$ 172.7					**$ 172.70**
12	DSHP - Temporary Coverage (AA Population)	State appropriation	Overall SNCP (AA)				$ 185.3	**$ 185.3**	$ 474.8					**$ 474.80**
13	Commonwealth Care	State appropriation	n/a	n/a	$ 305.1	$ 303.1	$ 152.5	**$ 760.7**						**$ -**
14	Infrastructure and Capacity-building	State appropriation	Infra.	Eligible providers	$ 3.0	$ 14.5	$ 26.0	**$ 43.5**	$ 20.0	$ -	$ 26.0			**$ 46.00**
					$ 1,387.8	$ 1,466.4	$ 1,475.8	**$ 4,330.1**	$ 1,958.5	$ 1,293.2	$ 1,265.7			**$ 4,923**

Expenditure Limits (STC ¶46)						
	SNCP Aggregate Cap (approved)			$ 4,400.0		SNCP Aggregate Cap (approved) $ 4,991.0
	(over)/under			$ 69.9		(over)/under $ 68.0
Subcaps		***Subcap***	***Expend.***	***(over)/under***	***Subcap***	***Expend.*** ***(over)/under***
Infrastructure Subcap (5% of SNCP cap)		*$ 220.0*	*$ 43.5*	*$ 176.5*	*$ 249.6*	*$ 46.0* *$ 203.6*
Provider Subcap		*$ 1,874.1*	*$ 1,794.2*	*$ 79.9*	*$ 1,874.1*	*$ 1,480.3* *$ 393.8*
DSHP Subcap		*$ 800.0*	*$ 780.9*	*$ 19*	*$ 800.0*	*$ 746.0* *$ 54*

#	Payment Type	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per SFY					Total SFY 2018-2022	Applicable footnotes
					SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022		
	System Transformation Incentive Based Pools										
1	Delivery System Reform Incentive Payments (DSRIP)	n/a		Participating ACOs, CPs and other uses as specified in STC XX	$425.00	$425.00	$400.00	$325.00	$225.00	$1,800.00	(1)
2	Public Hospital Transformation and Incentive Initiatives (PHTII)	n/a		Cambridge Health Alliance	$309.00	$243.00	$100.00	$100.00	$100.00	$852.00	(2)
	System Transformation Incentive Based Pools Subtotal				*$734.00*	*$668.00*	*$500.00*	*$425.00*	*$325.00*	*$2,652.00*	
	Disproportionate Share Hospital (DSH) Pool										
3	Public Service Hospital Safety Net Care Payment	DSH		Boston Medical Center	$20.00	$20.00	$20.00	$20.00	$20.00	$100.00	2
4	Health Safety Net Trust Fund Safety Net Care Payment	DSH	101CMR 613.00, 614.00	All acute hospitals and CHCs	$287.00	$287.00	$288.00	$288.00	$290.00	$1,440.00	(3)
5	Institutions for Mental Disease (IMD)	DSH	130 CMR 425.408, 101CMR 346.004	Psychiatric inpatient hospitals Community-based detoxification centers	$32.00	$32.00	$32.00	$32.00	$32.00	$160.00	(4)
6	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	DSH		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$51.00	$52.00	$52.00	$52.00	$52.00	$259.00	5
7	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	DSH		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	$105.00	$107.00	$107.00	$107.00	$107.00	$533.00	5
8	Safety Net Provider Payments	DSH		Eligible hospitals outlined in Attachment N	$180.00	$177.00	$176.00	$176.00	$174.00	$883.00	
	Disproportionate Share Hospital (DSH) Pool Subtotal:				*$675.00*	*$675.00*	*$675.00*	*$675.00*	*$675.00*	*$3,375.00*	
	Uncompensated Care (UCC) Pool										
9	Health Safety Net Trust Fund Safety Net Care Payment	UCC	101CMR 613.00, 614.00	All acute hospitals	$0.00	$10.00	$10.00	$10.00	$10.00	$40.00	3
10	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	UCC		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$65.00	$15.00	$15.00	$15.00	$15.00	$125.00	5
11	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	UCC		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	$147.00	$75.00	$75.00	$75.00	$75.00	$447.00	5
	Uncompensated Care (UCC) Pool Subtotal:				*$212.00*	*$100.00*	*$100.00*	*$100.00*	*$100.00*	*$612.00*	
	Total				**$1,621.00**	**$1,443.00**	**$1,275.00**	**$1,200.00**	**$1,100.00**	**$6,639.00**	
*Under section 1902(a)(13)(A)(iv) of the Social Security Act, states are required to make payments that take into account the situation of disproportionate share hospital (DSH) providers. As part of this Demonstration project, CMS has v											
	Aggregate SNCP Cap				**$1,621.00**	**$1,443.00**	**$1,275.00**	**$1,200.00**	**$1,100.00**	**$6,639.00**	
	ConnectorCare Subsidies										
12	DSHP – Health Connector Subsidies	n/a		n/a	$288.36	$315.32	$345.46	$379.16	$416.84	**$1,745.13**	6
	DSHP – Health Connector Subtotal				*$288.36*	*$315.32*	*$345.46*	*$379.16*	*$416.84*	***$1,745.13***	
	Grand Total SNCP				**$1,909.36**	**$1,758.32**	**$1,620.46**	**$1,579.16**	**$1,516.84**	**$8,384.13**	

ConnectorCare Subsidies

	Total Member Months	Total Subsidies Expenditures	Total Subsidies PMPM
SFY 2017	1,672,949	$ 204,150,000	$ 122.03
SFY 2018	1,793,402	$ 288,361,937	$ 160.79
SFY 2019	1,922,527	$ 315,318,447	$ 164.01
SFY 2020	2,060,948	$ 345,458,413	$ 167.62
SFY 2021	2,209,337	$ 379,157,788	$ 171.62
SFY 2022	2,368,409	$ 416,836,925	$ 176.00

Enrollment Growth SFY18-22

7.2%

Hypothetical Population Analysis

DRAFT - for policy discussion only

STC 73(a)(iii): Starting in SFY 2009, actual expenditures for the CommCare-19+20 and CommCare Parents [parents and caretaker relatives who would be eligible for base EGs, except for income] EGs will be included in the expenditure limit for the Commonwealth.

Starting April 1, 2010, actual expenditures for the CommCare-133 EG [<=133% FPL] will be included in the expenditure limit for the Commonwealth.

The amount of actual expenditures to be included will be the lower of the trended baseline costs, or actual per member per most cost experience for these groups in SFYs 2009-2011.

19 + 20 year olds

Member Months

	CommCare 19+20
SFY 2009	117,343
SFY 2010	108,929
SFY 2011	91,938
SFY 2012	70,986
SFY 2013	0
SFY 2014	0

Actual PMPM

	CommCare 19+20
SFY 2009	$ 374.33
SFY 2010	$ 391.76
SFY 2011	$ 419.21
SFY 2012	$ 399.63
SFY 2013	#DIV/0!
SFY 2014	#DIV/0!

Actual total expenditures
Used for WW Expenditures

SFY 2009	$ 43,925,128
SFY 2010	$ 42,673,532
SFY 2011	$ 38,541,369
SFY 2012	$ 28,367,948
SFY 2013	$ -
SFY 2014	$ -
	$ 153,507,977

Trended PMPM

	CommCare 19+20	
SFY 2009	$ 374.33	
SFY 2010	$ 400.35	7.0%
SFY 2011	$ 428.17	7.0%
SFY 2012	$ 447.13	5.3%
SFY 2013	$ 470.83	5.3%
SFY 2014	$ 495.78	5.3%

Trended baseline costs

SFY 2009	$ 43,925,128
SFY 2010	$ 43,609,471
SFY 2011	$ 39,365,262
SFY 2012	$ 31,739,970
SFY 2013	$ 34,425,009
SFY 2014	$ 37,336,720

Lesser of Actuals or Trended
Used for WOW Cap

SFY 2009	$ 43,925,128
SFY 2010	$ 42,673,532
SFY 2011	$ 38,541,369
SFY 2012	$ 28,367,948
SFY 2013	$ -
SFY 2014	$ -

CommCare Parents

Member Months

	CommCare Parents
SFY 2009	86,941
SFY 2010	101,210
SFY 2011	113,240
SFY 2012	116,834
SFY 2013	0
SFY 2014	0

Actual PMPM

	CommCare Parents
SFY 2009	$ 374.33
SFY 2010	$ 372.27
SFY 2011	$ 401.67
SFY 2012	$ 375.02
SFY 2013	#DIV/0!
SFY 2014	#DIV/0!

Actual total expenditures

Trended PMPM

	CommCare Parents	
SFY 2009	$ 374.33	
SFY 2010	$ 400.35	7.0%
SFY 2011	$ 428.17	7.0%
SFY 2012	$ 498.35	5.3%
SFY 2013	$ 524.77	5.3%
SFY 2014	$ 552.58	5.3%

Trended baseline costs

Lesser of Actuals or Trended

Used for WW Expenditures		
SFY 2009	$	32,544,698
SFY 2010	$	37,677,624
SFY 2011	$	45,484,664
SFY 2012	$	43,815,208
SFY 2013		42,057,862
SFY 2014		31,002,402
	$	232,582,459

SFY 2009	$	32,544,698
SFY 2010	$	40,519,364
SFY 2011	$	48,486,027
SFY 2012	$	58,224,347
SFY 2013	$	63,150,442
SFY 2014	$	68,491,989

Used for WOW Cap		
SFY 2009	$	32,544,698
SFY 2010	$	37,677,624
SFY 2011	$	45,484,664
SFY 2012	$	43,815,208
SFY 2013	$	42,057,862
SFY 2014	$	31,002,402

CommCare < 133% FPL (1902(k)(2))

Member Months	**CommCare <133 (k)(2)**
SFY 2009	N/A
SFY 2010	244,835
SFY 2011	949,547
SFY 2012	949,810
SFY 2013	0
SFY 2014	0

Actual PMPM	**CommCare <133 (k)(2)**	
SFY 2009	N/A	
SFY 2010	$ 396.60	
SFY 2011	$ 426.13	
SFY 2012	$ 407.89	
SFY 2013	#DIV/0!	
SFY 2014	#DIV/0!	

Trended PMPM	**CommCare <133 (k)(2)**	
SFY 2009	N/A	
SFY 2010	$ 397.48	
SFY 2011	$ 425.11	7.0%
SFY 2012	$ 498.36	5.3%
SFY 2013	$ 524.77	5.3%
SFY 2014	$ 552.58	5.3%

Actual total expenditures

Used for WW Expenditures		
SFY 2009		N/A
SFY 2010	$	97,101,247
SFY 2011	$	404,633,007
SFY 2012	$	387,422,325
SFY 2013	$	-
SFY 2014	$	-
	$	889,156,579

Trended baseline costs

SFY 2009		N/A
SFY 2010	$	97,317,635
SFY 2011	$	403,658,851
SFY 2012	$	473,347,312
SFY 2013	$	513,384,748
SFY 2014	$	556,809,132

Lesser of Actuals or Trended

Used for WOW Cap		
SFY 2009		N/A
SFY 2010	$	97,101,247
SFY 2011	$	403,658,851
SFY 2012	$	387,422,325
SFY 2013	$	-
SFY 2014	$	-

Essential 19+20 Hypothetical Population

DRAFT - for policy discussion only

1) STC 73(a)(iii): Starting in SFY 2009, actual expenditures for the Essential-19+20 EG (19 and 20-year old members enrolled in Essential) will be included in the expenditure limit for the Commonwealth. The amount of actual expenditures to be included will be the lower of the trended baseline costs, or actual per member per most cost experience for these groups in SFYs 2009-2014.

2) Expenditures for Essential 19+20 in SFY 2013 and SFY 2014 Q1&Q2 were estimated by multiplying total Essential expenditures by the ratio of Essential 19+20 member months to total Essential member months.

Member Months	Essential 19+20	all Essential	% 19+20
SFY 2009	57,938		
SFY 2010	81,721		
SFY 2011	91,598		
SFY 2012	89,796		
SFY 2013	86,079		
SFY 2014	40,743		

Actual PMPM	Essential 19+20
SFY 2009	$292.13
SFY 2010	$311.52
SFY 2011	$266.61
SFY 2012	$294.89
SFY 2013	$317.02
SFY 2014	$339.52

Actual total expenditures Used for WW Expenditures		
SFY 2009	$	16,925,270
SFY 2010	$	25,457,917
SFY 2011	$	24,420,584
SFY 2012	$	26,479,824
SFY 2013	$	27,288,877
SFY 2014	$	13,832,815
	$	134,405,287

Trended PMPM	Essential	
SFY 2009	$ 292.13	
SFY 2010	$ 312.43	7.0%
SFY 2011	$ 334.14	7.0%
SFY 2012	$ 378.31	5.3%
SFY 2013	$ 398.36	5.3%
SFY 2014	$ 419.47	5.3%

Trended baseline costs		
SFY 2009	$	16,925,270
SFY 2010	$	25,532,098
SFY 2011	$	30,033,750
SFY 2012	$	33,267,008
SFY 2013	$	36,081,065
SFY 2014	$	39,133,162

Lesser of Actuals or Trended Used for WOW Cap		
SFY 2009	$	16,925,270
SFY 2010	$	25,457,917
SFY 2011	$	24,420,584
SFY 2012	$	26,479,824
SFY 2013	$	27,288,877
SFY 2014	$	13,832,815

Duals with No Resource Test

				<<<ACTUAL		PROJECTED>>>		
	SFY12	SFY13	SFY14	SFY15	SFY16	SFY17	SFY18	SFY19
did not update expenditures			Expenditures			Expenditures		
BD - Base, Disabled	$871,998,229	$856,213,663	$922,846,853	$948,886,213	$1,022,276,868	$1,101,343,850	$1,177,468,737	$1,258,855,376
BF - Base, Families	$221,019,182	$223,426,156	$200,806,041	$227,751,279	$246,302,987	$266,365,843	$284,229,402	$303,290,963
RD - 1902(R)2, Disabled	$28,930,331	$29,746,821	$30,053,235	$21,955,954	$23,654,115	$25,483,619	$27,140,258	$28,904,592
TOTAL	**$1,121,947,742**	**$1,109,386,640**	**$1,153,706,129**	**$1,198,593,446**	**$1,292,233,970**	**$1,393,193,312**	**$1,488,838,397**	**$1,591,050,931**
updated member months Jan 2015			Member Months			Member Months		
BD - Base, Disabled	2,684,832	2,275,925	2,258,952	2,216,308	2,278,365	2,342,159	2,407,739	2,475,156
BF - Base, Families	1,982,742	2,017,239	1,783,831	1,923,190	1,977,039	2,032,396	2,089,303	2,147,804
RD - 1902(R)2, Disabled	173,273	19,327	18,885	13,165	13,534	13,913	14,302	14,703
TOTAL	**4,840,848**	**4,312,490**	**4,061,669**	**4,175,395**	**4,292,306**	**4,412,491**	**4,536,041**	**4,663,050**
			PMPM			PMPM		
BD - Base, Disabled	$324.79	$376.20	$408.53	$428.14	$448.69	$470.23	$489.03	$508.60
BF - Base, Families	$111.47	$110.76	$112.57	$118.42	$124.58	$131.06	$136.04	$141.21
RD - 1902(R)2, Disabled	$166.96	$1,539.13	$1,591.34	$1,667.72	$1,747.77	$1,831.67	$1,897.61	$1,965.92
TOTAL	**$231.74**	**$223.16**	**$243.59**	**$287.06**	**$301.06**	**$315.74**	**$328.22**	**$341.20**

TRENDS

Member Month Trend
2.80%

1115 Demonstration 2014 Renewal (June 2014) trend rate				1115 Demonstration 2017 Renewal trend rate			
	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Base Families	5.2%	5.2%	5.2%	3.8%	3.8%	3.8%	3.8%
Base Disabled/MCB	4.8%	4.8%	4.8%	4.0%	4.0%	4.0%	4.0%
1902 (r) 2 Children	4.6%	4.6%	4.6%	3.6%	3.6%	3.6%	3.6%
1902 (r) 2 Disabled	4.8%	4.8%	4.8%	3.6%	3.6%	3.6%	3.6%
1902 (r) 2 BCCTP	5.3%	5.3%	5.3%	3.6%	3.6%	3.6%	3.6%
Hypothetical Trends							
CommCare & Essential	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%
CommonHealth	4.8%	4.8%	4.8%	4.4%	4.4%	4.4%	4.4%

Community Partner Program Budget Report

		Behavioral Health Network					
Program Revenue	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
Estimated Enrollees- Start of Period (All Enrollees)		1,600	2,100	3,000	3,800	4,700	
Estimated Enrollees - End of Period (All Enrollees)		1,900	2,700	3,600	4,400	5,100	
Estimated Enrollees - Monthly Average (excl CBFS enrollees)		1,619	2,400	3,300	4,100	5,000	
Estimated Enrollees - Monthly Average (CBFS enrollees only)		110	110	110	110	110	
Estimated Program Revenue (excl CBFS enrollees)		$ 2,039,940	$ 5,184,000	$ 7,128,000	$ 8,856,000	$ 10,800,000	$ 34,007,940
Estimated Program Revenue (CBFS enrollees only)		$ 192,500	$ 330,000	$ 330,000	$ 330,000	$ 330,000	$ 1,512,500
Total Estimated Program Revenue		**$ 2,232,440**	**$ 5,514,000**	**$ 7,458,000**	**$ 9,186,000**	**$ 11,130,000**	**$ 35,520,440**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -	$ -	$ -	$ -
Revenue for Operations		**$ 2,232,440**	**$ 5,514,000**	**$ 7,458,000**	**$ 9,186,000**	**$ 11,130,000**	**$ 35,520,440**

Program Expenses		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Salary		$ 191,577	$ 1,995,290	$ 3,481,776	$ 4,268,184	$ 5,054,592	$ 5,841,000	$ 20,832,419
Fringe		$ 42,147	$ 438,964	$ 765,991	$ 939,000	$ 1,112,010	$ 1,285,020	$ 4,583,132
Total Personnel Costs		$ 233,724	$ 2,434,254	$ 4,247,767	$ 5,207,184	$ 6,166,602	$ 7,126,020	$ 25,415,551
Training & Professional Development			$ -	$ 6,000	$ 6,000	$ 6,000	$ 6,000	$ 24,000
Travel		$ -	$ 5,473	$ 13,670	$ 18,227	$ 22,784	$ 27,341	$ 87,495
Equipment			$ 72,255	$ 89,290	$ 107,660	$ 127,100	$ 146,540	$ 542,845
Supplies			$ 2,845	$ 3,767	$ 4,811	$ 5,859	$ 6,908	$ 24,190
Contract Services (consulting, professional)		$ -	$ 61,198	$ 155,520	$ 213,840	$ 265,680	$ 324,000	$ 1,020,238
Software licensing			$ -	$ -	$ -	$ -	$ -	$ -
Telecommunications			$ 22,000	$ -	$ -	$ -	$ -	$ 22,000
Occupancy (rent, utilities, maintenance)		$ 11,970	$ 70,000	$ 80,000	$ 110,000	$ 110,000	$ 110,000	$ 491,970
Other			$ 9,000	$ 10,000	$ 11,000	$ 10,000	$ 11,000	$ 51,000
Total Direct Costs		$ 245,694	$ 2,677,025	$ 4,606,014	$ 5,678,722	$ 6,714,025	$ 7,757,809	$ 27,679,289
Indirect Cost/Administrative Overhead	**11.3%**	**$ 27,763**	**$ 302,504**	**$ 520,480**	**$ 641,696**	**$ 758,685**	**$ 876,632**	$ 3,127,760
TOTAL EXPENSES		$ 273,457	$ 2,979,529	$ 5,126,493	$ 6,320,418	$ 7,472,710	$ 8,634,441	$ 30,807,049
Surplus/Shortfall		*$ (273,457)*	*$ (747,089)*	*$ 387,507*	*$ 1,137,582*	*$ 1,713,290*	*$ 2,495,559*	*$ 4,713,391*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Assistant Program Director	$ 70,000.00	0.83	1.25	$ 6,052
Nurse Care Manager	$ 84,000.00	2	1.25	$ 17,500
Clinical Care Manager	$ 58,000.00	2	1.25	$ 12,083
Care Coordinators	$ 36,000.00	16	1.25	$ 60,000
Admin Support	$ 30,000.00	1	1.25	$ 3,125
Enrollment Team Leader	$ 58,000.00	1	1.25	$ 6,042
Enrollment Specialists	$ 36,000.00	3	1.25	$ 11,250
COO	$ 150,000.00	0.1	7	$ 8,750
VP	$ 130,000.00	0.18	7	$ 13,650
AVP	$ 100,000.00	0.5	7	$ 29,167
Data Managers	$ 50,000.00	2	1.25	$ 10,417
Wellness Coach	$ 40,000.00	1	1.25	$ 4,167
Data Admin Support	$ 30,000.00	3	1.25	$ 9,375
Total Salary (Program Budget Line 1)		**32.61**		**$ 191,577.08**

For each position listed above, provide a brief statement of the position's responsibilities:

Assistant Program Director: Oversees multiple Care Management teams; hires staff; supervises clinical care managers; coordinates with other BHN programs; meets with external partners; troubleshoots day to day issues; develops program workflows.

Nurse Care Manager: Performs medication reconciliations; case consults on medically complex cases; reviews nursing and other assessments and provides synthesizes suggestions to member and teams; follows up with hospital transitions of care; develops care plans in conjunction with team.

Clinical Care Manager: Supervises a team of care coordinators; performs day to day operational functions; serves as a clinical consultant on cases with significant BH needs; develops care plans in conjunction with nurses.

Care Coordinators: Holds a member caseload; direct contact with members via phone and in-person encounters; assists with referrals, paperwork, benefit needs.

Admin Support: Front office support including faxing, paperwork management.

Enrollment Team Leader: Oversees all enrollment, marketing, outreach efforts; develops relationships with community and internal partners; oversees enrollment specialists making direct outreach to members; manages data workflows on new team assignments.

Enrollment Specialists: Makes direct outreach attempts to engage and enroll members and schedule required assessments/care plans.

VP: Develops and manages ACO and community partner relationships; sets strategic direction for BHN's Integrated Service lines including Care Management; serves as an Executive Sponsor to the CP program.

AVP: Oversees functions of all teams; sets direction for workflow management, day to day operations, and managed implementation of BHCP/LTSS CP.

Data Managers: Oversees flow of data coming into and out of BHN to meet contractual and quality requirements; oversee admin staff

Wellness Coach: Develops wellness programming for members; consults with teams on whole health strategies and incorporation of strategies into care plans; develops relationships with community partners in the wellness space

Admin Support: Tracks incoming and outgoing data elements; communicates needed data to teams/supervisors

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 191,577.08	22%	$ 42,147
Total Fringe (Program Budget Line 2)			**$ 42,147**

Total Personnel*	**$ 233,724**

* Should align with Personnel Costs row in Program Budget

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Total Training and Professional Development (Program Budget Line 3)			

Provide a description of each Training and Professional Development line item included in the table above:

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
				$ -
				$ -
				$ -
				$ -
				$ -

			Total Mileage	$	-

Travel Expense Description	Cost
Total Mileage	$ -
Parking and tolls	
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ -**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

Row 5 - Equipment

Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost
Total Equipment (Program Budget Line 5)			

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Total Supplies (Program Budget Line 6)			

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
Total Software Licensing (Program Budget Line 8)			

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
		Total Telecommunications (Program Budget Line 9)	

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent	1140	18	$ 11,970.00
Utilities			$ -
Repair and Maintenance			$ -
			$ -
			$ -
		Total Occupancy (Program Budget Line 10)	**$ 11,970.00**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

Add space to existing team locations, through procuring additional occupancy in health centers with integrated teams (Holyoke Health Center, Baystate High St. Clinic, etc.) and add space at Liberty Street to accommodate new teams.

1140 sq ft *$18/year = $20520
$20520/12 = $1710
$1710*7 months= $11970

Row 11 - Other

Other Direct Expense Description	Cost
Total Other (Program Budget Line 11)	**$ -**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	**11.30%**	

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Federally approved indirect rate for BHN

Community Partner Infrastructure Budget Report

		Behavioral Health Network					
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
PMPM Infrastructure Rate		$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
Engaged Enrollees		1,900	1,900	2,700	3,600	4,400	
Estimated Infrastructure Funds		$ 1,330,000	$ 1,961,920	$ 1,668,330	$ 1,961,425	$ 2,073,869	**$ 8,995,544**
At- Risk Withhold Rate			25%	44%	63%	81%	
Withhold			$ 484,511	$ 727,868	$ 1,227,093	$ 1,690,081	**$ 4,129,553**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 1,330,000	$ 1,477,408	$ 940,462	$ 734,332	$ 383,788	**$ 5,315,990**

Infrastructure Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology								
IT Staffing including Fringe		$ 134,098	$ 254,065	$ 435,540	$ 435,540	$ 435,540	$ 435,540	**$ 2,130,323**
Development Adaptation of EHR and/or Care Management System		$ 16,491	$ 196,800	$ 230,400	$ 316,800	$ 295,200	$ 360,000	**$ 1,415,691**
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Total Technology		$ 150,589	$ 450,865	$ 665,940	$ 752,340	$ 730,740	$ 795,540	**$ 3,546,014**
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses		$ 8,000	$ 8,000	$ -	$ -	$ -	$ -	**$ 16,000**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Total Workforce Development		$ 8,000	$ 8,000	$ -	$ -	$ -	$ -	**$ 16,000**
Business Start Up Costs								
Office Equipment (PBP & BP1 only)		$ -	$ 50,000.00					**$ 50,000**
Office Furniture (PBP & BP1 only)		$ -	$ -					**$ -**
Ramp-up Costs (PBP BP1, BP2 and BP3 only)		$ 273,457	$ 747,089	$ -	$ -			**$ 1,020,546**
Total Business Start Up Costs		$ 273,457	$ 797,089	$ -	$ -			**$ 1,070,546**
Operational Infrastructure								
Operation Staffing including Fringe			$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses			$ -	$ -	$ -	$ -	$ -	**$ -**
Total Operational Infrastructure		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Indirect Cost/Administrative Overhead Rate	11.3%	$ 17,921	$ 57,502	$ 75,251	$ 85,014	$ 82,574	$ 89,896	**$ 408,158**
TOTAL INVESTMENTS		**$ 449,967**	**$ 1,313,456**	**$ 741,191**	**$ 837,354**	**$ 813,314**	**$ 885,436**	**$ 5,040,718**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Care Management Software Project Manager	$ 75,000.00	1	7	$ 43,750
Data Warehouse Developer	$ 122,000.00	1	2	$ 20,333
HIE Interface Manager	$ 75,000.00	1	2	$ 12,500
HIE Interface Manager	$ 75,000.00	0.2	4	$ 5,000
IS Analyst- Report Writer	$ 85,000.00	1	4	$ 28,333
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary			$ 109,917
	Fringe rate	22.0%	Total Fringe	$ 24,182
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 134,098**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Care Mgmt Software Project Manager: Oversees implementation of CM software; serves as interface between software vendor and internal implementation team

Data Warehouse Developer: Architects/designs the infrastructure for managing for all incoming and outdoing data streams

HIE Interface Manager: Implements integration engine; communicates with external partners to design HIPAA and 42CFR compliant data-sharing solutions

IS Analyst: Develops, tests, and publishes reports in multiple formats (SSRS, data visualization) for use by program staff

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost

	A	B
34	CM Software Startup Implementation Expense	$ 16,491.00
35		
36		
37		
38		
39		
40	**Total Development and Adaptation of EHR and Care**	
41	**Management System**	$ 16,491.00
42	**(Infrastructure Budget Line 2)**	

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

BHN will procure a care management software platform that will provide us with the technology to drive population health management and which will incorporate quality metrics on performance and cost. We are prepared to implement an integrated platform that provides a coordinated approach to the management of chronic conditions between care managers, physician practices and the people that we serve in an effort to improve the coordination and access to care while decreasing the overall costs. The platform will introduce clinical innovations, care models and interventions to improve the outcomes for the high risk populations we will serve. Through the use of financial, clinical and operational analytics, BHN will incorporate data to track and forecast performance and workflow improvements.

Costs determined through a competitive RFP process , after working with an outside consultant to determine software needs. BHN

Row 3 - Technology for Service Delivery

Description of Expense	**Cost**

	A	B	C	D	E	F	G
67	**Total Technology for Service Delivery**						
68	**(Infrastructure Budget Line 3)**						
69							
70	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
71	***contract and how the costs were determined:***						
72							
73							
74							
75							
76							
77							
78							
79							
80							
81							
82							
83							
84							
85							
86	**Row 4 - Other Technology Expenses**						
87	**Description of Expense**	**Cost**					
88							
89							
90							
91							
92							
93							
94	**Total Other Technology Expenses**						
95	**(Infrastructure Budget Line 4)**						
96							
97	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
98	***contract and how the costs were determined:***						
99							

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 6 - Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses (Infrastructure Budget Line 6)	

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Row 7 - Training Expenses

Description of Expense	Cost
Training Consultant	$ 8,000.00
Total Training Expenses (Infrastructure Budget Line 7)	**$ 8,000.00**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Consultant to develop core competencies for Care Management; train staff through training cohorts; build web-based training library; consult on training needs identified by staff survey.

$50/hr * 8hrs/week * 5 months = $8000

Row 8 - Retention Expenses

Description of Expense	Cost

	A	B	C	D	E	F	G
199							
200							
201							
202							
203							
204							
205	**Total Retention Expenses**						
206	**(Infrastructure Budget Line 8)**						
207							
208	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms***						
209	***of the CP's contract and how the costs were determined:***						
210							
211							
212							
213							
214							
215							
216							
217							
218							
219							
220							
221							
222							
223							
224	**Community Partner Infrastructure Budget Report - Business Start Up Costs - Prep Budget Period**						
225							
226	**Row 9 - Office Equipment**						
227	Description of Expense	Cost					
228							
229							
230							

	A	B	C	D	E	F	G
231							
232							
233							
234	**Total Office Equipment**						
235	**(Infrastructure Budget Line 9)**						
236							
237	***Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were***						
238	***determined:***						
239							
240							
241							
242							
243							
244							
245							
246							
247							
248							
249							
250							
251							
252							
253	**Row 10 - Office Furniture**						
254	Description of Expense	Cost					
255							
256							
257							
258							
259							
260							
261	**Total Office Furniture**						
262	**(Infrastructure Budget Line 10)**						
263							

Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$

	A	B	C	D	E	F	G
295				**(Infrastructure Budget Line 12)**	$ -		
296							
297	***For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting***						
298	***the terms of the CP's contract:***						
299							
300							
301							
302							
303							
304							
305							
306							
307							
308	**Row 13 - Other Operational Expenses**						
309	Description of Expense	Cost					
310							
311							
312							
313							
314							
315							
316	**Total Other Operational Expenses**						
317	**(Infrastructure Budget Line 13)**						
318							
319	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms***						
320	***of the CP's contract and how the costs were determined:***						
321							
322							
323							
324							
325							
326							
327							

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**11.30%**	

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

To support administrative costs related to general IT, fiscal, and administrative support

Federally approved indirect rate for BHN

	A	B	C	D	E	F	G
358							
359							
360							
361							
362							
363							

Community Partner Infrastructure Allocation Worksheet

	Insert Contractor Name Here						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 1,330,000	$ 1,477,408	$ 940,462	$ 734,332	$ 383,788	$ 5,315,990
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL INVESTMENTS	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	CM Software	Select CM Software vendor/execute contract	01/01/18	02/01/18								
Technology	CM Software	Implement CM software	02/02/18	06/01/18								
Technology	Data Warehouse	Develop preliminary Data warehouse design	03/31/18	07/01/18								
Technology	HIE/Integration development	Map data streams with ACO partners	12/01/17	03/31/18								
Workforce Development	Training	Develop core competencies for Care Managers	11/01/17	01/01/18								
Workforce Development	Training	Publish web-based trainings; provide to existing staff	01/01/18	03/01/18								
Workforce Development	Training	Develop framework for training cohort to prepare for new staff	01/01/18	03/01/18								
Workforce Development												
Business Start Up Costs	Space	Secure additional team space	01/01/18	01/01/18								
Business Start Up Costs	Space	Relocate staff to new space	01/01/18	03/31/18	not hiring until mid April?							
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Staffing Operations	Hire new team staff	04/30/18	06/01/18								
Operational Infrastructure	Staffing Operations	Redeploy existing staff to new teams	04/30/18	06/01/18								
Operational Infrastructure												
Operational Infrastructure												

BH Community Partner - Staffing Model

Insert Contractor Name Here

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	1900	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	1.33	*Total management oversight of BH CP*
3	Medical Director		*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs	4	
5	Clinical Care Managers (RN)		*Do not include FTEs listed in line 4*
6	Clinical Care Managers (LPHA)	4	*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders	1	*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff		*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	28.5	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)		*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists	7	
12	Administrative Support	6	
13			
14			
	Total FTE	51.83	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1:400	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	1:8	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff: Clinical Care Managers; Assistant Program Directors

Section 7.3 Initial DSRIP Participation Plan
Subsection A. Executive Summary

1. BHN's 5-year business plan is to develop and add BHCP services to an already existing and robust care management infrastructure, which includes a dedicated Vice President of Integration as well as a Senior Program Manager of Population Health overseeing this department. As noted elsewhere in this response, our Population Health and Care Management Program currently provides CM services for One Care and the MBHP PBCM program. Together, these two programs currently serve more than 2000 Enrollees. Our program also serves the same areas for which we are applying to be a CP: the greater Westfield, Holyoke and Springfield areas. As a BHCP we will build upon our well developed and successful staffing structure and service models. Our teams of nurse care managers, clinical care managers, and care coordinators are already embedded, along with integrated behavioral health clinicians, at the Holyoke Health Center, and all four of Baystate's large community health centers in Springfield. These teams, along with CSP workers, Family Partners, Recovery Coaches and other BHN employees work side-by-side with primary care providers and care managers in these large, primarily MassHealth serving, primary care centers. We have worked in these territories for over 25 years and have visibility, frequent contact and established collaboration with families, social service and state agencies and healthcare. Our existing infrastructure, and these existing, solid relationships will allow us to "hit the ground running" and to rapidly add Enrollees in all areas. We will be able to immediately focus on helping our ACO partners to better support Enrollees, improve the quality of care, and reduce the total cost of care. BHN's process and outcome data with our One Care population (e.g., 30% reduction in hospitalization rates, significant reduction in average spending per member) demonstrate that we can be an effective collaborator to our ACO partners. We have already held initial discussions with all of the region's ACO applicants about creating an integrated, jointly-managed care management program, rather than separate, duplicative care management systems for physical and behavioral health.

One challenge that we face in care management is that the engagement of clients is often disconnected from the healthcare system. For many individuals with MH or SUD issues, engagement is most challenging if they have not been service recipients in either the healthcare or BH system. We have been very successful in engaging these individuals through our Health Policy Commission funded CHART program partnership with Mercy Medical Center, where we identify repeat visitors to the emergency department and support them in getting community services. We have also been successful at finding and engaging these individuals in our One Care and MBHP programs by designating specific staff, our Referral and Engagement Team, to seek them out in the community, connect with them, and encourage and support them in becoming engaged with our care management programs. As a BHCP we will use DSRIP funding to expand this team in each Service Area, and then sustain that with PMPM funding as our census grows. In our DSRIP plan, we will also fund creative technology solutions to promote engagement and oversight. We will modify and expand the marketing that has been in place for our current CM programs. We will train all staff in our "gates" (ESP, court clinics, central intake, outpatient, SUD programs), to connect to BHCP services for those eligible. Our existing policies and procedures will be modified, then used to train new staff being added for expansion. We have resource manuals for staff to use in assisting clients engage in their communities. These, too, will be updated as needed.

Another challenge to our 5-year development plan will be hiring staff with the credentials and interest in doing this work. It is an emerging field of work for professionals. With so many

new CPs across the region, we will be competing for staffing in a market which is low on qualified and experienced workers in this field. We will need to work on recruitment strategies that entice new staff to come to our program.

A third challenge will be encountered as CP staff attempt to triage clients into the service delivery system. Access to outpatient services, SUD treatment beds, and LTSS services is, and could remain, a challenge. ACOs will be looking for cost effective service delivery to manage needs of their clients. As a BHCP, we will work collaboratively with our ACO partners to identify treatment system issues and advocate or develop access where possible.

2. & 3. BHN plans to serve 4,734 Assigned and Enrollees across 3 Service Areas: 2,840 in Springfield, 1,420 in Holyoke, and 474 in Westfield.

4. As detailed above BHN's current extensive Case Management infrastructure and its robust administrative structure should allow for smooth development and implementation of our BHCP program. The Preparation Budget Period will be used to acquire a CM software package and other needed technology, as well as to begin developing modification to policies and procedures and quality measurement programs to comply with the specific requirements of the BHCP. We will work with our Material Subcontractors, to ensure their compliance with the performance specifications of a BHCP. Once assured of their ability to comply, we will establish referral, monitoring and reporting systems, to insure their delivery is incorporated into our own program's performance. We will also work with ACO partners during this period on establishing how to meet the contractual obligations. Much planning is needed on how to manage the BHCP population and the requirements of each party to ensure efficiency in referral, data sharing, approvals, and communication. For data sharing, a process is already in place and supported by a MeHI grant to BHN. However, we anticipate the need to expand this initiative, and to allocate resources for planning and implementation. We will hire and train the first teams of care managers to be ready to accept referrals 4/1/18. After that date, we will be well positioned for a steady growth in census already seen in our other CM programs. We anticipate that clients in our MBHP CM pilot and some of our CBFS clients may change how their care is managed. We will create communications and delivery of information to those clients to assist them in decision-making or transitioning to a new Care Management service.

Subsection B. Supporting Populations and Community Engagement

1. BHN has long-standing, extensive relationships with health, behavioral health, social support, and government sectors in the Springfield, Holyoke, and Westfield Service Areas, as well as across the Commonwealth. Our current care management services programs for One Care and MBHP share a resource directory of several hundred partners and referral resources for clients.

BHN is active in the state trade organization, Association for Behavioral Health, through which we cultivate relationships with our peer organizations and BHN is a leader in collaborations with our peers across the state. BHN partners on a number of initiatives with Clinical and Support Options, our Material Partner, which provides behavioral health services in four Western MA counties. BHN engages in collaborative relationships with Service Net in Hampshire County and multiple behavioral health providers in Hampden County, including Gandara, Pathways, MHA, and MSPCC.

BHN is a leading provider of integrated behavioral health services in more than a dozen primary care practices and is an active partner with six area hospitals and medical centers, including the three largest: BayState, Mercy and Holyoke Medical Centers. Enhanced communication and collaborations are expected with the implementation of BHN's Connected Communities grant. This grant from the Massachusetts E-Health Institute is enabling BHN to electronically share health information on consenting patients with other care providers across different health systems.

BHN is an active participant in the Early Childhood System of Care that is convened out of Springfield's Office of Health and Human Services, and supported by the Boston Public Health Commission. Through this venture, we are excited to continue to build bridges and communication opportunities among a large cross-section of agencies in our region who provide services to children and families. In addition, BHN has been the grantee for most of the past 15 years for the Department of Early Education and Care's (DEEC) Early Childhood Mental Health Consultation program in all four counties of Western Massachusetts. Through our partnership with Baystate High Street Pediatrics community health center, we are also the implementation team for a DPH replication of their successful Project LAUNCH program for early childhood mental health support in the primary care setting. BHN is in contractual relationship with DEEC's Coordinated Family and Community Engagement grantees to provide parent support and education programs in the community in partnership with housing providers, schools, preschool, and various community agencies.

We work with several government agencies. We have collaborated with DCF for many years providing a wide-range of child and family-specific interventions for their most needy children. Our collaboration with DMH began in year one of BHN's existence in 1937. We work in close partnership, as well, with DDS and DPH/BSAS for the clinical care and support needs of vulnerable populations living in our three anticipated BHCP service areas. We offer residential settings, outpatient and medication services, forensic services, day and peer supports in partnership with our state funders.

BHN partners with area shelters and housing authorities including Friends of the Homeless, Springfield Housing Authority, Way Finders (formerly HAP Housing) and Home City Housing. BHN provides parent education programs and direct therapy services to children and their parents, many of whom have co-occurring MI and SUD. BHN is also a member of the Western MA Network to End Homelessness, and as such partners with a variety of housing agencies as clinical services are needed. In addition, BHN participates actively on the McKinney Vento

homeless coalition in Holyoke and Springfield and provide contracted service delivery programs to the Springfield coalition. We work with the local Regional Employment Board to provide the evidence-based Talk-Read-Succeed Program, through which we offer parent education and support programs as well as individual services for children and their parents living in public housing. In addition, BHN is the recent recipient of an Innovation Grant from the Health Policy Commission to provide care management services to families living in shelter or public housing who are at risk of homelessness and for whom someone in the family has a mental health or substance use challenge. Through collaborative work with housing and community social service agencies, the goal is to support these families to stabilize and improve their health and behavioral health functioning and thereby reduce their total cost of care.

BHN participates in coalitions, task forces, and steering committees including the Springfield EOHHS Maternal Child Health Commission, Children's Behavioral Health Initiative (CSA Systems of Care meeting), National Alliance for Mental Illness (NAMI), public school Parent Advisory Councils (PAC), Hampden/ Wilbraham Safe Schools/ Health Students programs, coalitions such as Mason Square Health task force, the YEAH (Youth Empowerment, Adolescent Health) Network, New North Citizen's Council, and Holyoke Youth Task Force. We participate in Massachusetts Opioid Abuse Prevention Collaborative (MOAPC) Springfield 413, the Opioid Task Force in Franklin County, the Quaboag Hills Substance Use Task Force, Baystate Health Addiction Task Force, Westfield Drug Task Force and the Ware River Valley Domestic Violence Task Force.

Our collaborations with police across all three service areas are solid, with BHN co-responding to crisis situations and providing quarterly trainings and technical assistance to police Crisis Intervention Teams. We also collaborate with police in Ware, Warren, Belchertown, and Hardwick to help victims of domestic violence.

Vocational and educational partners help persons in BHN SUD programs who are in early recovery and reclaiming their preferred lives in the community. We work with Springfield Technical Community College, Career Point, and Future Works. Recovery support is offered at Gandara Center, Hope for Holyoke. Clubhouses and community resources for persons with mental health disorders include Human Resources Unlimited, Forum House and Lighthouse or the W MA Recovery Learning Center. Transitional age youth with early psychosis may receive a referral to Service Net's PREP West program.

2. BHN has a robust collaborative infrastructure in place due to the longevity and breadth of services we provide in Western MA. Care management and care coordination are core services in all three of our major services lines for persons impacted by SUD, MI, and I/DD. Given the intricate network of community connectivity we have already established, growing community connections is not a critical first step for BHN. However, the need for community connections is critical to our success. Therefore, we will continue actively cultivating our current community relationship and staying abreast of new agencies or programs with whom we should be collaborating.

3. New case management staff will have an orientation period wherein they become conversant in available community resources. BHN is developing plans to put resources in a format that is searchable and easy to update as community resources change often. BHN will develop a resource "data base" categorized by resource categories of services and providers. We will identify key information needed for effective search/sorting of resources. Existing resources will be sent to a centralized person for database maintenance and updating. This person may also

represent BHN in Community Meetings. This would prevent parallel processes that currently exist and free up resources within programs. Process for database development and maintenance:

- Resources will be verified and entered using agreed upon format
- A schedule for review of resources will be established so that each category will be reviewed at least annually
- Learning Activities will include accessing and verifying resources as well as identifying new resources. Any additions/discrepancies will be sent to the "Resource Coordinator".

Subsection C. Community Partner Supports and Activities
Subsection C1. Outreach and Active Engagement

a. It has been our experience that individuals are more receptive to engaging in care management when they understand the connection between care management and their trusted treatment providers. As such, we will attempt to leverage existing relationships within our own system of care, as well as within our large network of community partnerships to conduct strategic outreach and engagement with Enrollees, particularly with those who are more difficult to reach. BHN has extensive experience and an impressive track record with this type of outreach and engagement in our current One Care and MBHP care management programs.

Our first strategy is to research current treatment activity at BHN. If present, our care management team will reach out to the assigned treatment providers to alert them to their client's eligibility and ask for their support in engaging the Enrollee. Our Engagement Specialists will visit the Enrollee at the BHN treatment location at time of visit to explain the CP program and work toward enrollment.

Similarly, BHN operates integrated behavioral health partnerships with many of the ACO/ MCOs in our region. We will look to those ACO/ MCO partners for information on scheduled primary care appointments for targeted populations. Our BHN care management Engagement Specialists will contact current primary care providers and schedule to attend an upcoming appointment to discuss care management enrollment.

For Enrollees who do not have current BHN services or upcoming primary care visits, BHN Engagement Specialists will attempt initial outreach via phone call to the last known phone number. If unsuccessful by phone, BHN Engagement Specialists will outreach to the last known address. If the Enrollee is not home, BHN will leave contact information in the mailbox with a request for return phone call and offer of subsequent visit.

For Enrollees who are homeless and have no reliable phone, we will employ additional engagement strategies. BHN has significant experience with engaging this population, as seen most recently in our Health Policy Commission (HPC) funded CHART program with Mercy Medical Center's Emergency Department, as well as our own Mission West, CSPECH and Project Hope programs. All four programs routinely engage chronically homeless individuals who have untreated MI or SUD. For this work, BHN primarily leverages our partnerships with the homeless shelters and other homeless services providers (e.g., food pantry, HealthCare for the Homeless, etc.) as well as local police departments. Our staff regularly visit those service locations as well as common outdoor homeless encampments to find individuals and engage them in needed health and behavioral health care. Initial contact with the Enrollee will be conducted within 30-days of assignment and at least one face-to-face contact will be conducted within 90-days of assignment.

b. The strategies outlined above will be employed for individuals with mental health disorders as well as those with substance use disorders. BHN maintains a full continuum of substance use treatment options which may be providing treatment for Enrollees at the time of assignment into Community Partner care management services. We will therefore begin by attempting to reach these individuals through current BHN treatment programs, or through their primary care visits, as outlined above.

c. BHN has extensive experience with the process of obtaining and documenting Enrollee's agreement to participate in CP supports as evidenced in our current care management census of 2000+ individuals. Both One Care and MBHP require participants to sign an agreement to participate in our care management services.

BHN plans to develop written materials explaining the benefits, design and purpose of the CP supports. This will include information on BHN and its providers as well as how our CP supports will work as a team with their other current and future treatment providers. We will discuss what Protected Information (PI) we intend to obtain, use and share with the individual's treatment team for the purposes of providing CP supports. Written materials will also include information on the process for Enrollees to engage with BHN's CP supports as well as their option to opt out or request assignment to a different CP if they prefer.

If our first contact with the Enrollee is via a shared visit at a treatment provider (BHN or partner provider), or in person visit at home or community location, our Engagement Specialists will bring the written materials and participation form and use it as reference in explaining the services. We will discuss with the Enrollee all items outlined in written documents, including benefits, design and purpose, PI sharing and option to opt out/ change assignment. All concerns or questions will be answered and clarified. If the Enrollee agrees to enroll, our Engagement Specialists will ask the Enrollee to sign the participation form in that visit. If the Enrollee would prefer to opt out or requests assignment to a different CP, we will note that as well, and share the information with appropriate entities.

If the first contact with the Enrollee is via a phone contact, the Engagement Specialist will discuss the benefits, design and purpose of the services as well as their option to opt out or request a different assignment. If the Enrollee gives verbal permission to participate, the Engagement Specialist will schedule an appointment for the comprehensive assessment at a future time, but before 90 days post initial assignment. The BHN staff member conducting the comprehensive assessment will bring the written materials and participation form to that visit. The staff will again explain the purpose of the participation form as confirmation of the Enrollee's agreement to participate in CP supports, explain the benefits, design and purpose of the CP supports, the need and plan for sharing PI, and the option to opt out or change assignment. If the participant agrees to continue, they will be asked to sign the participation form prior to beginning the scheduled comprehensive assessment. In addition, the participant will be asked to sign a written authorization to the uses and disclosures of his or her PI as necessary for providing CP supports.

Subsection C2. Comprehensive Assessment and Person-Centered Treatment Planning

a. During the initial contact, we will attempt to confirm Enrollee's agreement to participate in the program, via verbal (if on the phone) or written acceptance of the participation form. At that time we will explain that the first step of the CP Support Program is to meet with their care coordinator to review their current services and needs. We will then attempt to schedule the Enrollee for a comprehensive assessment with a member of our care management team. This appointment will be scheduled at a time and place convenient for the Enrollee, but no later than three months after the original Enrollee assignment date. If the Enrollee is unable to confirm a future appointment date with us during our initial contact, they will be asked when a good time would be to call again and their name will be placed on a list of Enrollees to be called at that later date. BHN staff will attempt to reach the Enrollee via phone or in-person visits until an assessment is scheduled or until the Enrollee is determined to no longer be interested in or available for CP supports. Once the comprehensive assessment appointment is scheduled, BHN will send an automated text and/or phone reminder (based on individual preference) to the Enrollee 24-hours prior to their assessment appointment.

At the appointed time, the BHN team member will arrive at the chosen location with written materials on the CP Support Program, participation form (if not yet signed), authorization forms for communicating with the individual's treatment team members and the comprehensive assessment form. All members of the BHN CP Support Program will be trained in principles of motivational interviewing, client engagement, and person-centered planning. Staff will use these tools to engage the client in discussion of their needs and goals and how the CP Support Program can help them achieve their goals. Through this process, the identified information required for the comprehensive assessment tool will be obtained. Currently BHN's two care management programs utilize two different assessments, as defined by the funder. The One Care Program uses the MDS assessment tool, entered directly into the electronic health record for the Commonwealth Care Alliance. However, similar to the current proposal, MBHP's Practice-based Care Management Program required providers to create an assessment tool covering specific identified domains. BHN created the Health Needs Assessment (HNA) to meet the requirements of that particular program. Many of the data points contained in the CP supports comprehensive assessment are covered in the MDS and HNA. However, additional questions are proposed herein to be added to those assessments for a complete assessment which addresses all required data points. Finally, with DSRIP funding, BHN proposes to complete our process of selecting and implementing a care management software package. It is our expectation that the pre-loaded and modifiable assessments contained in these software packages will address the required data elements for the CP supports comprehensive assessment or be modifiable to add any missing fields. Therefore, the exact wording and layout of questions may change from this submission with the adoption of care management software.

As an integral part of the assessment process, the Enrollee will be engaged in a process to identify the goals and interventions which will comprise their treatment plan. Following the assessment appointment, the workflow plan will be implemented. The medical needs, medical history and medications will be reviewed by the team's registered nurse and the entire comprehensive assessment will be reviewed by the team's behavioral health clinical care manager. This assessment will be used to inform the creation of the treatment plan.

Results of the comprehensive assessment will be communicated to the Enrollee's care team, ACO/MCO and other providers on the care team. It is our expectation that this assessment will be communicated electronically between BHN's care management software and the medical

record of the PCP. BHN has been engaged in a Connected Communities project through MA eHealth Institute to create interfaces between BHN and our primary care partners at Baystate and Holyoke Health Center. Workflows, interfaces and protocols built through this process will be the critical foundation upon which we build the process and protocols for electronic exchange of the comprehensive assessment and subsequently the treatment plan for the CP Supports Program.

b1.The Enrollee will be initially engaged in the person-centered treatment planning process at the time of the comprehensive assessment. BHN's solution-focused approach to care guides our assessment process to define goals, hopes and vision as part of defining needs. Therefore, as part of conducting the comprehensive assessment, the BHN care team member will engage the Enrollee in defining long and short term goals for their health and wellness and determine what types of support and services might be indicated to work toward goals.

Following the assessment appointment, medical needs, medical history and medications will be reviewed by the team's registered nurse and the entire comprehensive assessment will be reviewed by the behavioral health clinical care manager. Additional data on the Enrollee's needs will be gathered from primary care, behavioral health and other providers involved with the individual's care. The CP Support Care Team will use this information from providers as well as the input from the Enrollee to develop a treatment plan which outlines the long and short term goals for reducing risk and helping to manage the individual's health conditions as well as the types, frequency and duration of services recommended to support the individual in achieving their goals. The Person Centered Treatment Plan (treatment plan) will also include any anticipated barriers to meeting goals as well as proposed interventions to overcome those barriers. The plan will include a section addressing potential behavioral health or medical crises and how the individual and care team members will respond to prevent or intervene. Finally, the care plan will include contact information for all care team members, including providers and the Enrollee as well as specific dates for reassessment.

b2. BHN has been researching care management software for the past year and will purchase and implement a solution with DSRIP funding. Our comprehensive assessment and treatment plan documents will be live documents in the software. From the products we have reviewed, it is our expectation that the BHN team will work with the software vendor to customize the fields in the comprehensive assessment and treatment plan to reflect the domains being assessed in the CP Support Program. It is our expectation that needs identified in the assessment will translate into tentative goals in the treatment plan, to be modified as needed by the treatment team and Enrollee upon review. It is our expectation that the treatment plan will include discrete sections to articulate short and long term goals, specifics on services and programs recommended and agreed upon patient self management approaches. The BHN CP Support Team member assigned to be the on-going care coordinator for the Enrollee will be responsible for ensuring that the treatment plan is complete and accurate. The care coordinator will review the completed treatment plan with the Enrollee and their assigned PCP for final input, make changes based on their input, and will send a final copy to all designated care team members, providers, ACO/MCO and other state agencies or providers serving the Enrollee.

b3. The treatment plan will be updated every six months and following a change in the Enrollee's health status. Such a change will reflect a consistent pattern, impact more than one area of health status, will not be self-limiting and may be related to a progressive disease, decline in functioning, presentation of a new problem or goal, or resolution of a prior goal.

The care coordinator and the Enrollee will discuss the need for each 6-month reassessment one month in advance of the reassessment due date. At that time, the reassessment appointment

will be scheduled for a time and place convenient for the Enrollee. The care coordinator will conduct the reassessment at the appointed time. The focus of the reassessment will be to re-assess health status, determine progress to date towards prior goals, assess on-going relevance for existing goals and potential need for revision/ modification and determine goodness of fit of the current treatment plan for meeting needs. The care coordinator will complete documentation of the reassessment and will update the treatment plan as appropriate. If the treatment plan has been updated, the Care Coordinator will follow the same protocol as outlined above for the initial plan with regard to getting approval from the Enrollee and PCP. A final copy of the treatment plan will be shared with the Enrollee and PCP as well as other treatment team members as appropriate, via electronic exchange wherever the care team member has IT interoperability.

b4. BHN's person-centered approach to care in all of our treatment programs informs our system for ensuring client participation in the treatment planning process and in the documentation of the treatment plan. For example, in our outpatient system, BHN expects staff to implement 'collaborative documentation' practices which require that documentation of the visit be completed at the time of the visit with client input. In addition, our treatment plan template in the electronic health record has a field requiring the staff to attest that they shared the treatment plan with the client. Person-centered philosophy, practices, and accountability systems are established practices at BHN. In our care management programs, we have similar systems in place to ensure that the engaged members participate in the development of their care plan and receive a copy of the final plan. This experience and infrastructure in our treatment and care management programs will inform our process for ensuring that the Enrollee in the CP Support Program approves the treatment plan. Enrollees will be included in the development of their treatment plan and they will be asked to sign off on the initial plan developed collaboratively with them. Following review by the nurse care manager and clinical care manager as well as input from other providers (including PCP), the treatment plan will be finalized. If any changes are indicated by this input, the Enrollee will be contacted via phone or in person to discuss the changes and get their verbal approval or address any concerns. The final treatment plan will mailed to the Enrollee and this will be noted in our electronic record, for the purpose of accountability tracking.

Our process for ensuring PCP approval of the treatment plan will be informed by our experience partnering with PCPs to develop models of integrated behavioral health and care management in their primary care practices over the past 4+ years. Through this experience, BHN leadership, staff and our partner primary care practices have developed workflows and tracking systems to share the results of our assessments and interventions. BHN is currently funded through MeHI to develop electronic information exchange between BHN and Baystate, and between BHN and Holyoke Health Center, partners in our two largest integrated programs. We will use this experience to inform establishing electronic exchange between our new care management software and the PCP record to share the treatment plan. For those primary care practices not ready to receive information exchanged electronically, we will set up systems to share in hard copy the treatment plan. Systems will be created for the PCP to acknowledge receipt of the plan, which will denote review and approval of the plan.

Subsection C3. Care Coordination and Care Management

BHN will draw on our experience with Wraparound (National Wraparound Initiative) in the Children's Behavioral Health Initiative as well as our experience with care teams in our current care management programs to inform our approach to satisfying the Care Coordination and Care Management requirements of the CP Support Program. In the Wraparound approach, clients are the center, and individuals from their natural support system are key members of their care team. In addition, in our current care management program, the primary care provider, behavioral health provider, nurse care manager, clinical care manager and care coordinator together comprise the core of the care team.

3a.To identify all stakeholders, BHN will explore a few specific avenues. Initial assignment of the Enrollee will include some information on relevant stakeholders. Whether assignment comes from the ACO or MCO directly or from EOHHS, we assume that it will include information on the primary care assignment as well as relevant behavioral health provider history. For those Enrollees with treatment history through BHN, the CP Support Program staff will research our electronic health record to determine names of current behavioral health providers. When conducting the comprehensive assessment, BHN staff will explain the concept of a care team and share information about BHN staff who will be on the care team (nurse care manager, clinical care manager and care coordinator) and will request names of primary care and behavioral health provider to be included as well. Enrollees will be encouraged to identify additional individuals they would like to include on the care team, such as family member, other informal caregivers, state agencies or advocates. The care team membership will designed from this list of professional and informal stakeholders according to the needs and preferences of the Enrollee.

3b. BHN plans to share information with the care team stakeholders through electronic, telephonic and in-person methods. In our current One Care and MBHP Practice-based Care Management programs, those care management teams are collocated in the larger primary care practices and have access to the electronic health record at BHN and the PCP. BHN's care management team (care manager, care coordinator or nurse care manager) meet with the primary care providers as needed and communicate regularly via secure email about the members' needs and progress towards goals. BHN's care management team frequently attends medical visits with members and through that venue exchanges information with PCP, the member and any additional support people the member has brought to the appointment. Similarly, the BHN care management team connects via phone or in person with the specialty behavioral health providers to collaborate and share information, and they document all activities in BHN's EHR. BHN care management team keeps in regular contact with additional outside providers via phone and/or secure email to ensure progress towards treatment goals. These contacts are documented in BHN's electronic record and updates are shared with the PCP as appropriate.

3c. BHN will identify members of the Enrollee's care team through a number of avenues. The original assignment from EOHHS or the ACO will presumably identify the primary care provider and any behavioral health history with provider information. The Enrollee will also be asked to identify providers and natural supports to participate on the care team. BHN's care management team will help care team members understand the goals and functioning of the care team as well as their role, appropriate to their licensure, training and relationship to the Enrollee. BHN care management team will keep a record of care team members' names, contact information and relationship to the Enrollee.

3d. Care coordinators and our electronic records will provide the primary mechanisms for ensuring effective ongoing communication across all stakeholders. Care coordinators will be responsible for developing and maintaining relationships with the providers and other care team members involved with the Enrollee. With partners who are connected electronically through our care management software, care coordinators will monitor activity related to the member, including primary care visit notes, hospital notes, or activity with other care providers. As needed, the care coordinator will contact these providers or care team members via phone, email or face to face to follow-up on the activity and implications of that activity on the Engaged Member's progress towards their stated goals in the treatment plan.

Where electronic exchange is possible, information on the work of the care team will be shared with the providers (primary care and behavioral health) and stored in their electronic health records for future reference. For example, the final treatment plan will be documented in BHN's electronic record and a copy will be electronically shared with the PCP, provided their system is able to receive this information. For those PCPs without health information exchange capacity, a hard copy of the plan will be shared via secure email or secure fax, to be input into their health record. For those partners able to conduct electronic exchange, BHN's system will be set to send updates automatically when on-going updates are noted in BHN's care management and treatment electronic records or via email, phone or face to face contact, as needed.

Subsection C4. Care Transitions

BHN's approach to care transitions is informed primarily by our experience with the One Care and MBHP Practice-based Care Management programs and is based on elements outlined in Dreyer, T (2014) "Care Transitions: Best Practices and Evidence-based Programs" http://www.chrt.org/publication/care-transitions-best-practices-evidence-based-programs/

Key elements of BHN's care transitions approach include understanding the Enrollee's assessment by treatment providers before discharge, engaging the Enrollee in revising care plan goals, coaching the Enrollee in self-management, medication reconciliation and on-going communication with Enrollee and sending/receiving providers during and after transitions.

Prior to an Enrollee's discharge or change in treatment settings, the appropriate member of the BHN CP Support Care Management Team will work with the Enrollee and their PCP, ACO, MCO and inpatient/outpatient providers to create an appropriate discharge plan. The appropriate member of BHN CP Care Team will be present for discharge planning meetings at the treatment setting to discuss after care, understand medication and treatment needs and begin coaching on self-management. The BHN CP Care Team member will follow-up with the Enrollee in a face to face visit within three business days following transition in care. The focus of that meeting will be to answer any questions and ensure that the Enrollee understands the discharge plan, medication administration and self-management plans. The BHN CP Care Team member will update the treatment plan to reflect the change in functioning evidenced by the care transition as well as any new medication, self-management goals and recommended services. Finally, the BHN CP Care Team member will work with the Enrollee to coordinate referrals and participation in recommended after care services. This may include a care team member facilitating a face to face introduction between the Enrollee and the provider of services to which they are being referred, attending the recommended follow-up visits with the Enrollee or supporting the Enrollee in attending the recommended appointments by helping arrange transportation and following up with the Enrollee after missed appointments. BHN CP Care Team member will also share records with the new providers to which the Enrollee has been referred, to ensure fully coordinated care.

Subsection C5. Medication Reconciliation

As part of our care management protocols for One Care and MBHP clients, BHN conducts medication reconciliation (MR) for all newly enrolled members, as well as for any member discharged from an inpatient stay. This MR includes contacting the member's PCP and other providers. Because our CM teams are embedded in so many large health centers and PCP practices, having access to their EHRs in many cases, we are able to review all medications prescribed by the PCP, as well as any prescribed by BHN providers. We reach out to the member's other known providers and check with their pharmacy to ensure that all prescriptions are accurate and being filled as prescribed. Our RNs do all of this in collaboration with the member, educating them along the way about their medications, answering questions, providing materials, and helping them to better understand the importance of taking their medications as prescribed. We are currently investigating technological supports to help our more challenged members to better manage their daily medication regime. At a large FQHC, where our on-site CM staff manage more than 500 members, we have reviewed pharmacy expense data and have identified the members whose pharmacy costs are the highest. We are working with pharmacists to engage these members in Medication Therapy Management (MTM), a best practice in working with individuals and their providers to ensure safety, accuracy and adherence to a coordinated medication regime. BHN recently signed an agreement with Genoa to build an on-site pharmacy at our Liberty Street site, and as part of this agreement, Genoa will provide several hours each week of pharmacist time to work with our CM staff and members on MTM. For any member who is participating in a MAP, we coordinate with the member's MAP provider as well as their PCP and the rest of their treatment team.

We have also modified our EHR forms and workflow to include a medication review process. We use the ePrescribing module of our EHR to document medications prescribed by internal and external prescribers. By entering them into our ePrescribing module, we are able to view contraindications and alerts on the medications and their interactions with allergies.

Additionally, our prescribers are being trained in the use of the MassPAT system, starting with our physicians and APRNs who work with individuals with substance use histories. MassPAT is the Massachusetts Prescription Awareness Tool and is the product of the Massachusetts Prescription Monitoring Program (MA-PMP). The MA-PMP collects dispensing information on Massachusetts Schedule II through V controlled substance dispensed prescriptions. The MA-PMP analyzes data to determine prescribing and dispensing trends; provides patient prescription history information to prescribers and dispensers and provides educational information to health care providers and consumers.

Subsection C6. Health and Wellness Coaching

a. BHN has an extensive history of engaging those we serve in health and wellness understanding, planning, and engagement. Several years ago we received a SAMHSA Primary Care – Behavioral Health Integration grant, wherein we developed health and wellness programming both at our Liberty Street campus and at large, local health centers. Each client worked with staff on a Person-Centered Health and Wellness Plan. Plan components included (as needed) smoking cessation classes at BHN, walking/fitness/exercise programs, or chronic disease (e.g., diabetes, hypertension) education and self-management.

A master's level clinician provided behavioral health supports to clients enrolled in the Diabetes Clinic at Mason Square Health Center. Our clinician assessed clients for behavioral health or substance use issues impacting their ability to manage their diabetes, and assisted them with developing strategies to manage these issues via a care manager. The diabetes clinic was focused on reducing patients' Hgb A1C scores.

Other BHN programs employ a variety of strategies towards health and wellness for clients. Adults in our Day Treatment Programs at Liberty Street Clinic have been provided with weekly health and wellness groups utilizing the *Solutions for Wellness* curriculum. As a recovery-based, illness and life-skills management resource, *Solutions for Wellness* assists people with serious mental illness to better understand their illness, strengthen resilience and partner with their treatment team. It incorporates physical health and wellness into the recovery process. This curriculum addresses areas such as healthy eating, weight management, cardio-vascular health, and stress management. We have also provided a *Whole Health Action Management* (WHAM) group for our Day Treatment clients. WHAM is a training program and peer support group model developed by CIHS to encourage increased resiliency, wellness, and self-management of health and behavioral health among people with mental illnesses and substance use disorders.

Our residential programs offer YMCA or fitness club memberships to those we serve, often providing staff supports as needed. Memberships regularly include nutritional counseling to our residents, as well as smoking cessation education and supports. Nurses in these programs regularly offer in-service trainings on cooking and dietary health, as well as individualized education regarding diabetes, respiratory health, and eating disorder management. They also offer a harm reduction training to teach staff interventions that can be used for clients in the early stages of making health changes.

All of these strategies are made available to members enrolled in our care management programs as well, (i.e., CCA One Care and MBHP PBCM), and will be part of the plan we develop with Enrollees in our BHCP.

b. BHN plans to procure a care management software package that will guide and document our care planning process. The comprehensive assessment will identify wellness needs and suggest areas for wellness goals. BHN CP Support program staff will work with Enrollees to identify the wellness goals that they are interested in working towards, as informed by the comprehensive assessment and wellness resources available at BHN and in the community. Goals and interventions will be documented on the treatment plan, as well as the goals in other areas of medical and behavioral health care. Care coordinators will be responsible for checking regularly with Enrollees and their care team providers as to progress on health and wellness goals. Updates will be added to the care plan as appropriate.

Subsection C7. Connection to Community and Social Services

The first step to getting community and social services in place is to identify what the individual's community and social services needs are. BHN plans to employ a standardized screening tool to identify social determinants and social needs for each Enrollee. We plan to select the specific tool once our care management software vendor has been selected, so that our tool can be well integrated into the software system. There are currently two tools which are in use or being considered for use by partners in our community. Caring Health Center is currently using the PRAPARE tool, (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences).

http://www.nachc.org/wp-content/uploads/2016/09/PRAPARE_One_Pager_Sept_2016.pdf

This evidence-based tool is endorsed by the National Association for Community Health Centers and covers core areas of Race, Education, Ethnicity, Employment, Migrant and/or Seasonal Farm Work, Insurance, Veteran Status, Income, Language, Material Security, Housing Status, Transportation, Housing Stability, Social Integration and Support, Address or Neighborhood, Stress as well as additional areas of Incarceration History, Safety, Refugee Status, and Domestic Violence.

Baystate Health is also spearheading a community coalition, in which BHN is an active member, to adopt the social determinants screening tool and cloud based platform Health Leads Reach. https://healthleadsusa.org/solutions/enable/health-leads-reach/. This evidence-based model is accessible on care coordinators' hand held devises and not only offers screening and assessment tools, but also links to a pre-loaded database of local community resources to which our team can refer Enrollees to meet the identified need.

A factor in BHN's selection of a care management software platform will be its ability to integrate with one of these social needs screening tools and/or have a comparable tool already loaded in the software. Our final decision about which tool to use will be based in part on that selection process. However, the final product will include the dimensions reflected in these two evidenced-based screening tools.

BHN proposes to formally screen all Enrollees as part of our initial comprehensive assessment process. Goals on the care plan will reflect identified social needs, and corresponding interventions/ referrals to community and social services will be reflected as well in care plan for each Enrollee.

Care coordinators will be primarily responsible for staying connected with Enrollees and with the community resources they are referred to. In their regular prescribed contact with Enrollees, as well as any as-needed contact, care coordinators will review the social needs interventions and referrals to ensure that suggested services are meeting identified needs. If not, care coordinators will work with Enrollees to identify barriers and strategize solutions to those barriers.

Subsection D. Innovative Technologies for Service Delivery

BHN is on the verge of investing in a care management software platform that will provide us with the technology to drive population health management and which will incorporate quality metrics on performance and cost. We are prepared to implement an integrated platform that provides a coordinated approach to the management of chronic conditions between care managers, physician practices and the people that we serve in an effort to improve the coordination and access to care while decreasing the overall costs. The platform will introduce clinical innovations, care models and interventions to improve the outcomes for the high risk populations we will serve. Through the use of financial, clinical and operational analytics, BHN will incorporate data to track and forecast performance and workflow improvements.

BHN will need to hire a dedicated Project Manager (one FTE) to structure and successfully lead the teams responsible for the implementation of this application and workflow. The candidate must have a high degree of care management expertise in order to assist BHN in achieving the maximum benefit from the technology.

BHN will continue the development of its integrated data warehousing strategy and business intelligence interface to provide financial, clinical and operational analytics. The data warehouse will become the main source of information for report generation and analysis via reporting tools that can be used for such things as ad-hoc queries, canned reports, and dashboards. As information is crucial to the continuous quality improvement in outcomes and managing the total cost of care, this development is critical in achieving our vision. To accomplish this we will need to upgrade our virtual network environment by adding additional server capacity with the necessary Business Intelligence (BI) analytics. A Data Warehouse BI Developer position (1 FTE) will be added to the Information Systems Department to lead that project.

BHN is already advancing its ability to interface with our ACO partners through the purchase of an integration engine that will serve to connect our care management software and electronic health record with the electronic health records of our ACO partners. This tool will also allow us to transmit information about the care of those we serve with partner social service agencies in any format and to any specified secure location regardless of their internal electronic exchange capabilities.

BHN will expand the use and deployment of smart phones and mobile tablets to the CP Staff and high risk individuals we are care managing. Mobile apps will be employed to support the monitoring and self-maintenance of these clients to support healthier functioning. As a result, expenses will be incurred to provide coverage plans to use those devices. To prevent the loss or breach of data, we will deploy a mobile device management software solution to track and secure BHN's mobile devices in the field. The application will provide the ability to locate, lock, and potentially wipe lost devices. BHN will use geofencing capability so that alerts can be generated to insure additional personal security.

Subsection E. Personnel and Staffing

1. Subsection E Attachment Programmatic Response Org Chart

2.

Service Area	FTE Administration	FTE Supervision	FTE Care Mgmt	FTE Care Coordinators
Springfield	4.2	2.4 + →	14.2	59.8
Holyoke	2.1	1.2 + →	7.10	30.4
Westfield	.7	0.4 + →	2.36	10.4

BHN currently has a very well developed Population Health and Care Management Program. We contract with CCA for the One Care population, and MBHP for their Practice-based Care Management Program. Our staffing model for these programs, developed with both national consultation and learned experience, is what we would propose as a BHCP in the Springfield, Westfield, and Holyoke Service Areas.

Starting at the level closest to the enrolled member, our program utilizes Care Management Teams that are comprised of a masters or doctoral level behavioral health clinical care manager (CCM) and a nurse care manager (NCM). These two lead the Team and supervise up to eight Care Coordinators / Health Outreach Workers. Each of these ten FTE Teams is able to provide quality care management for approximately 400 enrolled members. Therefore, the number of teams and care managing staff would scale in each Service Area as enrollment grew.

BHN's Care Management teams are currently located at a variety of sites. Some teams work out of community-based BHN sites. Other teams are co-located in the region's large health center and are integrated with BHN's on-site Integrated Primary Care Behavioral Health Teams. For example, our CM team at Baystate's Mason Square Health Center works in an integrated structure with BHN's BH clinicians, CSP workers and CBHI staff, as well as with Mason Square PCPs and Baystate care managers. This has proved to be an extremely effective staffing and structuring model for locating and engaging members, and for coordinating care with primary care providers. As a BHCP, we will continue with and build upon this model for referred or Enrollees.

The CCM and NCM report to an assistant program director (APD), who typically oversees up to three teams. APDs report to BHN's Assistant VP for Population Health and Care Management. Also reporting to this Assistant VP is the supervisor of the team responsible for member engagement and enrollment. This team is comprised of several outreach workers who mostly focus on locating and engaging members, and RNs who perform initial comprehensive assessments.

Additionally, we staff a number of administrative support positions and data managers. The data managers enter, process, and generate reports related to established quality measures, and have a dotted line reporting relationship to the BHN VP for Clinical Quality as well.

3. BHN utilizes a variety of strategies to recruit qualified, diverse applicants. Our single most successful recruiting and hiring strategy is the successful retention of students in a wide variety of disciplines completing their internship at BHN, graduating from their program, and then remaining at BHN as an employee. Each year BHN hosts and trains more than 100 interns from psychology doctoral, social work, mental health counselor, marriage and family therapy, public health, and other related programs. Our peer specialists come from our own persons served, NAMI or RLC. Peers recruit other peers for BHN. We work with the Regional Employment Board, Career Point, MCDI, and Mass Rehab, as examples, to hire for BHN. Our goal as a

BHCP will be to continue to build a competent and diverse staff, robust enough to meet the enrollment targets we have established for this program.

Once notified that have been selected as a BHCP, our timeline for expanding care management staff is such that we will be fully ready to begin accepting referrals on April 1, 2018. Because our care management infrastructure is already in place, we are willing and able to negotiate an earlier start date to begin active BHCP services.

4. In our current Population Health/Care Management Program, we have been extremely successful at recruiting and hiring staff as the numbers of enrolled members has increased. Our current staffing of five managers, seven supervisory level clinical care managers, 11 RNs, and 42 care coordinators and health outreach workers includes 36 individuals who are bilingual in Spanish, three individuals who speak a second language other than Spanish, and 47 individuals whose race or ethnicity reflect those of the large Latino (36, or 55%) and African-American (11, or 17%) populations we serve. When we have accessed Certified Peers or Certified Recovery Coaches from those departments at BHN to work with enrolled members, those individuals as well have brought cultural and linguistic diversity to our program. We also advertise on multiple on-line sites; hold career and job fairs both in the community and at local colleges; offer recruiting bonuses to BHN staff for their help in attracting candidates; and have close connections with local college programs. We recruit from South Florida and Puerto Rico for bilingual/bicultural staff.

5. BHN is developing a comprehensive training and orientation system for staff in our care management programs, which is based on the successful system recently developed for our Primary Care Behavioral Health program via a grant from the Commonwealth Corporation's Workforce Transformation Grant. The system includes three primary interlocking components: core competencies needed to be successful in the role; online and in person training modules designed to address the learning objectives required to achieve proficiency in each core competency; and a supervisor framework for monitoring acquisition and application of core competencies in the on-going work. The core competencies required for the care coordinator position are as follows: Methods & Strategies for Referrals, Effective Communication, Culturally Responsiveness , Care Coordination & System Navigation, Writing and Technical Communication Skills, and Professional Skills & Conduct. Each competency has 6- 10 benchmark activities which reflect level of skill development in that competency area. For example, the competency of Care Coordination and System Navigation is broken down into the following benchmark activities:

A. Obtain and share up-to-date eligibility requirements and other information about health insurance, public health programs, social services, and additional resources to protect and promote health.

B. Work collaboratively as part of a care team.

C. Coordinate and assist in implementing care plans, in cooperation with clients and professional colleagues. (Care plans should be based on needs and resource assessments. Plans should describe how each party involved will help meet the goals and priorities defined in collaboration with clients.)

D. Provide care coordination, which may include but not be limited to facilitating care transitions, supporting the completion of referrals, and providing or confirming appropriate follow-up.

E. Provide support for clients to use provider instructions or advice, and convey client challenges to IBHC

F. Make referrals and connections to community resources to help individuals and families meet basic social needs

The training modules are designed to teach people these skills in order to deliver competent care coordination and system navigation. The trainings modules are delivered through a number of modalities to provide variety and address different learning styles, including web-based lessons created in Articulate Storyline software, individual meetings and group meetings. Each module has a quiz at the end and a passing grade is required before continuing to the next module.

The first two weeks of employment, the new staff have a set schedule which intersperses each learning module with shadowing, meetings with mentors and supervisors and hands on practice. The new hires are considered still in training for the first 6 months, during which time there is frequent assessment by supervisor of their progress on the learning objectives and benchmark activities. The supervisor notes where the staff is in the progression from Novice to Emerging, to Meets Expectation to Exceeds Expectation and what examples are evident in their work to substantiate that level.

Each job role (care coordinator, clinical care manager, nurse care manager, supervisor, etc.) will have a system of core competencies, training modules to teach the benchmark activities and supervisory/ evaluation structure to monitor acquisition of knowledge skills.

6. BHN employs a wide variety of staff retention strategies. Based upon national survey data that clearly indicate factors such as "relationship with direct supervisor" and "feeling of competence and possessing tools to do the job" are key to staff retention, we place a heavy emphasis on providing staff with intense and ongoing training, and an individual supervisor with whom they feel they have a positive working relationship. Because we are a large agency, we are able to use upward evaluation data to ensure that supervisors are experienced by their staff as supportive and providing needed guidance and training.

Clearly, other key factors in retaining staff are compensation and opportunities for advancement. BHN has been financially stable for many years, and we have been able to provide staff with periodic raises and occasional non-standard compensation at years' end. In our care management programs, where we have a number of value-based incentives, we met our targets and have been able to pass some of our incentive payments on to staff in those programs. BHN offers a comprehensive benefit package and strives to provide a family supportive environment for its staff.

Employees are offered and encouraged to pursue ongoing professional development courses and BHN provides paid time for such training. For employees pursuing further education, BHN has internship and clinical opportunities available. BHN also participates in the state Massachusetts Loan Repayment Program (MLRP) and the National Health Service Corps (NHSC) loan repayment programs which serve as an incentive for many clinically trained staff to join and remain at BHN. Existing employees are encouraged to recommend colleagues, neighbors, friends and families who possess the skill and talent needed for our community interventions; current employees may be eligible for significant bonuses for difficult to fill positions if their referral results in a successful hire.

Subsection F. Implementation Plan and Timeline

Subsection F Attachment Preparation Budget Timeline

Subsection F Attachment Quarterly Implementation Plans

Subsection G. Budget Report and Budget Narrative

1. Attachment B- Budget Report
   a. Budget Reports shall be based on the number of Assigned and Enrollees in each Service Area indicated by the Bidder on Attachment D.
   b. Attachment B must be completed and submitted in an Excel format to EOHHS.
2. Attachment C-Budget Narrative
   a. Bidders shall submit a detailed Budget Narrative for the Preparation Budget Period and Budget Period 1.
   b. The Bidder shall submit Budget Narratives for Budget Periods 2-5 that are summarized by project.

Subsection H. Sustainability

BHN will use DSRIP funds for two significant expenses. The first is the purchase and implementation of care management software. Because the purchase and the majority of implementation expenses are one-time costs, sustainability should not be an issue for these expenses. One potential cost, to be decided during implementation planning with the new software company, is the need for IT/IS staff responsible for ongoing product functionality and maintenance. This staff position will need to be sustained. Also, all products under consideration have ongoing monthly fees based upon the number of Enrollees registered within the software. The larger the number of Enrollees, the smaller the per Enrollee fees. As we explore care management software, we are consulting with our BHCP partners, and other collaborator organizations to research a product that could be shared among a number of organizations. This might be able to give us an economy of scale to keep Enrollee fees low. This optional strategy is not guaranteed.

Much of BHN IT/IS costs for infrastructure are managed across the larger system. Our EHR, Accounting and HRIS software are currently supported in the overhead cost structure. These costs will not substantially change after the initial term of this program. Thus, the new ongoing costs will be sustained as one of the costs supported by the established PMPM base rate plus the decreasing additional infrastructure payments received during the initial Contract Term. By the end of the term our plan would be that the large numbers of Enrollees that we plan to serve would provide us with a sufficient economy of scale to not only meet personnel and program operating expenses, but to be able to sustain the costs of the monthly CM software user fees. It is assumed that at the end of the 5 years, the PMPM will need to be negotiated with the ACO/Medicaid, taking into consideration the contributions BHN has made to reducing overall costs and meeting other performance outcomes. Our history to date demonstrates that we can meet targets, and we have received incentive payments. These additional revenues will help us sustain this program as well.

The second area where BHN plans to use DSRIP funding is hiring and training additional managers, clinical care managers, nurse care managers, and care coordinators, as well as (a fewer number of) wellness coaches, peers, and administrative support staff. As there will be no PMPM revenue during the Preparation Budget Period, DSRIP funds will be used to support some staff. However, during this period we will continue to provide CM services to MBHP PBCM Pilot members, and the staff serving these 600+ members *will* be supported by the MBHP PMPM payments. Our assumption is that many of these members will qualify for BHCP services, and on 4/1/18 will transition into the BHCP program. At that point. the staff serving them will also transfer from being MBHP funded to being supported by BHCP PMPM funding. Then, during the early years of the contract term, as the program is expanding its census continues to grow, infrastructure support funding will be used to cover costs of personnel and program operations not supported by the monthly base PMPM payments. Again, as the program grows, there should be sufficient economy of scale to allow for decreasing dependence on these infrastructure funds, and an increasing ability of PMPM funds to cover all costs associated with running a high quality BHCP program.

Subsection I. Quality Management and Performance Monitoring

BHN's Quality Improvement program ensures that services to individuals are delivered in a manner that is person-centered, improves their health and well being, is cost effective, and meets accreditation and regulatory requirements. These aims are considered in the context of a rapidly changing health care environment.

The Quality Program focuses on Population Health, the Experience of Care, and Per Capita cost. Population Health refers to using information from various sources to improve and inform service delivery. This includes using clinical data to understand the risks and needs of individuals served and ensuring we meet the necessary outcomes. The Quality Team works with various units at BHN to determine their data needs, acts as the liaison with the Information Systems and Electronic Health Record staff, and facilitates the training and use of this information to aid in the delivery of services. The team runs queries on data to understand risks and outcomes with clients and works with the various clinical teams to address the issues and concerns.

Experience of Care is aimed at improving how clients, staff and external partners can improve their processes and outcomes. BHN uses surveys with clients, staff and providers to understand their perceptions and to understand our challenges in providing care. These surveys' include data on health disparities based on race, ethnicity, gender and geography. Additionally, the Quality Team reviews and simplifies workflows to improve the efficiency and experience of clients and staff. For instance, process improvements have occurred with our Substance Use, Crisis, and Integrated Primary Care programs to enhance and standardize our documentation and work with health care partners.

The Quality Program audits client records and meets with clinical staff to ensure that client care is well documented and meets person-centered standards. This ensures that treatment incorporates evidence-based, effective practices with a broad range of trainings and knowledge. We review reports on connections to care, incidents, and utilization to ensure that services are provided in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and all providers of care.

Per Capita cost is the understanding that new models of care involve reimbursement based on the needs of the whole client, and so the integration and care management of those services become critical to meet the needs of the clients within fixed resources. The Quality Team supports this model by working with service providers to understand the costs and review the benchmarks for high risk and high cost clients. This allows the agency to address the client needs and work to reduce overall costs of care.

2. BHN will pursue two quality measure outcomes in the first budget period. The first will be the 'initiation and engagement of alcohol and drug dependence treatment for individuals served'. BHN has developed an extensive set of mental health and substance use related programs over the years. Staff already work to address the co-occurring nature of these disorders, and we believe that improvements in care and recovery are dependent on our ability to integrate care for both disorders. The markers of success will be *an increase in the number of services* that address both substance use and mental health disorders, *increases in the number of treatment plans* that include both sets of problems and goals, and an increase, based on the consumer survey of individual who specify that their services are for both substance and mental health issues. This will be demonstrated by metrics obtained from our service data, review of charts in our audits, and the data collected in our consumer satisfaction survey that specifically asks about the types of behavior health problems addressed in their services.

The second outcome will be timely follow up with individuals who have been psychiatrically hospitalized. This measure has long been viewed as a critical part of care. BHN has existing reports and processes to address this follow up. We have developed an automatic notification system wherein clients who go to the Crisis Program (a step toward all types of hospitalization) have their care and service staff notified. This allows staff to quickly follow up on all clients that are at risk for any type of inpatient behavioral health need. BHN has also developed an electronic monitoring form and set of reports that track all types of hospitalizations. This electronic system prompts staff to follow up with clients with specific time frames, usually 48 hours and 7 days. This process has been shown to be very effective. BHN programs that have tracked hospitalizations have met the thresholds for response at over 90% (7-1-16 to 12-31-16) and reduced hospitalizations by over 30% for the care managed population.

3. To achieve goals, the Quality Program has a comprehensive team that includes Quality Analysts, the Clinical Director, the Human Rights Director, Department of Professional Development (DPD) staff and a Project Manager. Quality Analysts perform the hands-on analysis, documentation and implementation of yearly quality initiatives. The Clinical Director provides the guidance and direction of clinical initiatives to meet the needs of our client population. The Human Rights Director ensures that clients are treated with respect and investigates concerns in care. The DPD organizes and facilitates the various trainings to ensure a workforce that addresses administrative and client-centered needs. Our Project Manager oversees major implementations to facilitate a thoughtful, timely process for change management.

The Quality Program is overseen by the agency Program Committee whose sole focus is the Quality Program. This committee includes four members of the Board of Directors, CEO, Vice President of Quality, Clinical Director, and members of management and staff representing many levels of care, including managers from the Crisis Program, Developmental Services, Residential Substance Use programs, and Outpatient Services and Care Management programs.

The Quality Program is accountable to all Senior Vice-Presidents who oversee the array of clinical and care management programs. The Quality Program works closely with the Electronic Health Record team and the Information Systems team responsible for overall agency reporting.

Subsection J. Coordination with ACOs and MCOs

1. For over two decades, BHN has been doing business through contracts, joint initiatives, grants and integrated care with the healthcare systems that cover the Springfield, Holyoke and Westfield Service Areas. All of our historical healthcare partners have applied to be an ACO or part of an ACO in our region. The hospitals are Baystate Health, Sisters of Providence Health Systems, and Holyoke Medical Center. Our community health centers and Federally Qualified Health Center partners are Mason Square Neighborhood Health Center; Brightwood Health Center; High Street Health Centers (adult and pediatrics) Holyoke Health Center and Caring Health Center. We have been integrating clinicians, CSP workers and care managers into these setting for many years. Group and primary care practices with whom we do collaborative BH-Primary care integration include Holyoke Pediatric Associates, Pediatric Care Associates, Mercy Medical Practices, Pediatric Associates of Hampden County, Family Medicine Associates, Chestnut Medical Associates, Valley Medical Associates and a number of other primary care practices. Our embedded staff includes master's level clinicians, community support workers, care managers (for One Care and MBHP Provider-based CM), peers, Family Partners, and Recovery Coaches. We also partner with many MCOs: Health New England, BMC Healthnet, MBHP/Beacon, Commonwealth Care Alliance. Each has applied for inclusion in an ACO in our service territory or is currently a Health Home. For over three years, we have been managing care and fulfilling the CP role in service to 2000 covered lives for CCA and MBHP. Relationships with healthcare partners have enabled us to be successful in planning, implementing, and problem-solving for a variety of regional integrated and coordinated services.

These varied and successful collaborative efforts have positioned BHN to establish working relationships with hospital system executives as well as medical leadership. Our CEO meets periodically with all hospital CEOs and negotiates our agreements. She can pick up the phone to discuss and problem solve as needed. Other BHN leaders have regular meetings with those within our partners' organizations charged with developing and delivering services. Since BHCP began planning in earnest, we have been conducting regular meetings with all of these partners, sharing intent and plans for CPs within their systems. As each prepared their own ACO applications, we consulted on options for integrated care management departments with health and BHCPs working jointly together. Our One Care initiative with Holyoke Health Center (currently more that 700 enrolled members) has demonstrated to them the value of a joint CM department, and it is their plan to maintain this if BHN is selected as a CP for their Medicaid members. Therefore, it is fair to say, that the necessary relationships to negotiate contracts with ACOs and MCOs in our territory are already established, and in some cases, the planning has begun. Our skills and expertise in care management have already been demonstrated to those who have applied to be an ACO. We have met with each and have agreed to meet again, once all decisions have been made on ACOs and BHCPs. Each has agreed that our historical relationship ensures they will work with us, as we have demonstrated value to them already in their primary care practices and specialty populations served. BHN has already established the relationships to plan, contract, implement, and manage outcomes for care management partnering with the proposed ACOs.

2. Branding and marketing for our Whole Health Care Management program has already taken place due to our One Care and MBHP pilot programs. We have brochures, marketing materials for our healthcare partners to use with their assigned lives, materials that physicians use to educate their patients on the concept and value of care management services. BHN's Care Management Department has established protocols for client engagement and outreach that have

been successful in building our program quickly and engaging clients assigned to us. The templates for marketing and systems for engagement already exist and will be modified during the ramp up phase once ACOs are selected and we are invited to the table to do more detailed planning on our involvement in launching the ACOs in our service territory.

3. We have already met with each ACO applicant in our region. We have agreed with all that once ACO awards are made, we will be invited to talk further about our role as a BHCP. They each have assured us that we will be at the table with them, as we already have service delivery and care management in place with all of them. We will strategize further with them how this will fit into their plan for ACO implementation. Steve Winn, SVP and Kathy Moss, VP for Healthcare Integration, will be our leads in communication with the ACOs on plans for implementation. They have been the leads in One Care and our MBHP PBCM pilot. Drs. Winn and Moss have also been the leads in the implementation of our Integration of BH into primary care practices initiatives which have been operational for many years.

4. BHN holds many contracts with our healthcare partners mentioned above (e.g., ESP services). Within each current contract, there is a Conflict Resolution section that outlines the process for conflict resolution, the participants in the process, and the mechanism for resolution in the event that the process fails. We have experienced that each healthcare partner has their preferred process for conflict management, so these agreements will need to be individually negotiated by leadership and legal counsel of both parties to the agreement. This will then be inserted into the MOU/Contract between the ACO and BHN as a BHCP.

We also have built into each contract, regular meetings among key staff of both parties who are responsible for managing the integrated programming. They may occur weekly, monthly or quarterly, depending on the need. These meetings have been found to provide low-level problem solving in real time, negating the need for a higher level of problem solving and conflict resolution. Our collaborative service delivery models build in processes for good dialogue and team approaches to delivery so that our program staff successfully manage many issues before they become problems. We will use this same model in working to establish coordinated and, hopefully, integrated care management with our ACO partners.

Community Partner Program Budget Report

		Behavioral Health Partners of MetroWest LLC (BHPMW) BH CP					
Program Revenue	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
Estimated Enrollees- Start of Period (All Enrollees)		0	1,400	2,625	2,975	3,325	
Estimated Enrollees - End of Period (All Enrollees)		1,400	2,625	2,975	3,325	3,500	
Estimated Enrollees - Monthly Average (excl CBFS enrollees)		1,220	2,288	2,593	2,898	3,050	
Estimated Enrollees - Monthly Average (CBFS enrollees only)		180	338	383	428	450	
Estimated Program Revenue (excl CBFS enrollees)		$ 1,537,200	$ 4,942,080	$ 5,600,880	$ 6,259,680	$ 6,588,000	$ 24,927,840
Estimated Program Revenue (CBFS enrollees only)		$ 315,000	$ 1,014,000	$ 1,149,000	$ 1,284,000	$ 1,350,000	$ 5,112,000
Total Estimated Program Revenue		**$ 1,852,200**	**$ 5,956,080**	**$ 6,749,880**	**$ 7,543,680**	**$ 7,938,000**	**$ 30,039,840**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -	$ -	$ -	$ -
Revenue for Operations		**$ 1,852,200**	**$ 5,956,080**	**$ 6,749,880**	**$ 7,543,680**	**$ 7,938,000**	**$ 30,039,840**

Program Expenses		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Salary		$ 90,635	$ 1,108,424	$ 3,287,198	$ 3,833,704	$ 4,442,248	$ 5,044,306	$ 17,806,515
Fringe		$ 19,477.00	$ 238,200	$ 706,419	$ 823,863	$ 954,639	$ 1,084,021	$ 3,826,619
Total Personnel Costs		$ 110,112	$ 1,346,624	$ 3,993,617	$ 4,657,567	$ 5,396,887	$ 6,128,327	$ 21,633,134
Training & Professional Development			$ 97,300	$ 90,000	$ 25,500	$ 25,500	$ 14,100	$ 252,400
Travel			$ 29,908	$ 96,228	$ 109,583	$ 126,400	$ 138,137	$ 500,256
Equipment				$ 249,638	$ 280,423	$ 323,818	$ 355,457	$ 1,209,336
Supplies		$ -	$ 46,693	$ 154,588	$ 180,455	$ 207,736	$ 225,230	$ 814,702
Contract Services (consulting, professional)		$ -	$ -	$ -	$ -		$ -	$ -
Software licensing						$ -		$ -
Telecommunications			$ -	$ -	$ -	$ -	$ -	$ -
Occupancy (rent, utilities, maintenance)		$ -	$ 39,879	$ 123,657	$ 136,108	$ 157,425	$ 173,971	$ 631,040
Other		$ -	$ 12,936	$ 40,877	$ 45,794	$ 52,892	$ 58,111	$ 210,610
Total Direct Costs		$ 110,112	$ 1,573,340	$ 4,748,605	$ 5,435,430	$ 6,290,658	$ 7,093,333	$ 25,251,478
Indirect Cost/Administrative Overhead	**12.0%**	**$ 13,213**	**$ 188,801**	**$ 569,833**	**$ 652,252**	**$ 754,879**	**$ 851,200**	$ 3,030,177
TOTAL EXPENSES		$ 123,325	$ 1,762,141	$ 5,318,438	$ 6,087,682	$ 7,045,537	$ 7,944,533	$ 28,281,655
Surplus/Shortfall		*$ (123,325)*	*$ 90,059*	*$ 637,642*	*$ 662,198*	*$ 498,143*	*$ (6,533)*	*$ 1,758,185*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Care Coordinator	$37,000	12.75	1	$ 39,313
Clinical Care Manager- RN	$80,000	2.55	1	$ 17,000
Clinical Care Manager- LMHP	$60,000	1.02	1	$ 5,100
BH CP Manager	$75,000	1.5	2	$ 18,750
Quality Manager	$55,000	0.26	1	$ 1,192
Peer Specialist	$37,000	2.5	1	$ 7,708
Administrative Assistant	$37,000	0.51	1	$ 1,573
				$ -
Total Salary (Program Budget Line 1)		**21.09**		**$ 90,635.00**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 90,635.00	21%	$ 19,477
Total Fringe (Program Budget Line 2)			**$ 19,477**

Total Personnel*	**$ 110,112**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

Care Coordinator- *works on-site at the Consortium Entities (CEs) and Affiliated Partner (AP) and provides CP supports and activities to assigned and engaged enrollees*

Clinical Care Manager- *RN- works on-site at the CEs and AP, performs RN functions as required in model contract including assessment sign off and medication reconciliation; supervises care coordinators in collaboration with LMHP clinical care manager; consults to team; provides CP supports to assigned and engaged enrollees iwth comples needs in collaboration with the assigned care coordinators.*

Clinical Care manager- LMHP- *works on-site at the CEs and AP, reviews and signs off on comprehensive assessments; primary supervisor of the care coordinators in collaboration with RN clinical care manager; consults to team; provides CP supports to assigned and engaged enrollees iwth comples needs in collaboration with the assigned care coordinators.*

BH CP Manager- *works on-site at the CEs and APs and manages the daily operations of the BH CP program on-site at respective CEs and AP agencies; overees care coordination teams and the provision of CP suports*

within the CE or AP.

Quality Manager- *works on-site at the CEs and AP and ensures the implementation of BHPMW BH CP's quality improvement plan iwthin the assigned CE or AP agency; tracks and monitors internal and external quality measures; facilitates flow of quality related data and information to and from the BHPMW BH CP and the assigned CE or AP agency.*

Peer Specialist- *Peer wtih lived experience with mental health conditions, physical health conditions, and/or medical conditions, and/or those why are parents of members wtih such conditions. They will work on-site at CEs and AP and provide peer support and recovery coaching. These staff will be instrumental in fostering member engagement.*

Administrative Assistant- *works on-site at the CEs and AP and provides overall administrative support to the CE's and AP's BH CP teams.*

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
NONE			
Total Training and Professional Development (Program Budget Line 3)			

Provide a description of each Training and Professional Development line item included in the table above:
NONE

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
NONE				$ -
				$ -
			Total Mileage	

Travel Expense Description	Cost
Total Mileage	$ -
Parking and tolls	
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$** -

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees. ***NONE***

Row 5 - Equipment

Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost
NONE			
Total Equipment (Program Budget Line 5)			

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined: NONE

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
NONE			
Total Supplies (Program Budget Line 6)			

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined: NONE

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
NONE			
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS. NONE

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
NONE			
Total Software Licensing (Program Budget Line 8)			

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined: NONE

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
NONE			
		Total Telecommunications (Program Budget Line 9)	

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined: NONE

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent	NONE		#VALUE!
Utilities			$ -
Repair and Maintenance			$ -
			$ -
		Total Occupancy (Program Budget Line 10)	

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined: NONE

Row 11 - Other

Other Direct Expense Description	Cost
NONE	
Total Other (Program Budget Line 11)	

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined: NONE

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	**12.00%**	**$ 13,213.00**

	A	B	C	D	E	F
160						
161						
162	***Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:***					
163						
164						
165	*The newly created BHPMW LLC does not have a federally approved rate. We utilized Advocates, a Consortium Entity, federally approved rate of 12%.*					
166						
167						
168						

Community Partner Infrastructure Budget Report

		Behavioral Health Partners of MetroWest LLC (BHPMW) BH CP						
Infrastructure Investment Funding		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
PMPM Infrastructure Rate			$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
Engaged Enrollees			1,400	1,400	2,625	2,975	3,325	
Estimated Infrastructure Funds			$ 980,000	$ 1,445,625	$ 1,621,987	$ 1,620,900	$ 1,567,185	**$ 7,235,697**
At- Risk Withhold Rate				25%	44%	63%	81%	
Withhold				$ 357,008	$ 707,650	$ 1,014,056	$ 1,277,163	**$ 3,355,877**
TOTAL MAXIMUM FUNDS AVAILABLE		$ 450,000	$ 980,000	$ 1,088,617	$ 914,338	$ 606,844	$ 290,022	**$ 4,329,820**
Infrastructure Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology								
IT Staffing including Fringe		$ 45,742	$ 327,490	$ 254,341	$ 257,813	$ 120,513	$ 105,951	**$ 1,111,850**
Development Adaptation of EHR and/or Care Management System		$ 125,000	$ 80,000	$ 60,000	$ 60,000	$ 60,000	$ 60,000	**$ 445,000**
Technology for Service Delivery		$ -		$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses			$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ -	**$ 20,000**
Total Technology		$ 170,742	$ 412,490	$ 319,341	$ 322,813	$ 185,513	$ 165,951	**$ 1,576,850**
Workforce Development								
Workforce Development staffing including Fringe			$ 72,799	$ -	$ -	$ -	$ -	**$ 72,799**
Recruitment Expenses		$ 5,000	$ 20,000	$ 20,000	$ 10,000	$ 10,000	$ -	**$ 65,000**
Training Expenses		$ 15,000	$ 68,187	$ 58,902	$ 57,091	$ 24,453	$ 15,596	**$ 239,229**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Total Workforce Development		$ 20,000	$ 160,986	$ 78,902	$ 67,091	$ 34,453	$ 15,596	**$ 377,028**
Business Start Up Costs								
Office Equipment (PBP & BP1 only)		$ 18,107.00	$ 84,774.00					**$ 102,881**
Office Furniture (PBP & BP1 only)		$ 1,500.00	$ 7,500.00					**$ 9,000**
Ramp-up Costs (PBP BP1, BP2 and BP3 only)		$ 123,325	$ -	$ -	$ -			**$ 123,325**
Total Business Start Up Costs		$ 142,932	$ 92,274	$ -	$ -			**$ 235,206**
Operational Infrastructure								
Operation Staffing including Fringe		$ 53,152	$ 123,650.00	$ 437,839.88	$ 380,001.00	$ 277,859.00	$ 33,401.00	**$ 1,305,903**
Other Operational Expenses		$ 28,173	$ 85,600	$ 135,897	$ 46,468	$ 44,000	$ 44,000	**$ 384,138**
Total Operational Infrastructure		$ 81,325	$ 209,250	$ 573,737	$ 426,469	$ 321,859	$ 77,401	**$ 1,690,041**
Indirect Cost/Administrative Overhead Rate	12.0%	$ 35,001	$ 105,000	$ 116,638	$ 97,965	$ 65,019	$ 31,074	**$ 450,696**
TOTAL INVESTMENTS		**$ 450,000**	**$ 980,000**	**$ 1,088,617**	**$ 914,338**	**$ 606,844**	**$ 290,022**	**$ 4,329,821**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
IT Project Manager	$113,000	0.3	6	$ 16,950
IT System Configuration Staff	$128,410	0.2	5	$ 10,701
IT Support (Help Desk) staff	$ 60,000.00	1	2	$ 10,000
				$ -
	Total Salary			$ 37,651
	Fringe rate	21.5%	Total Fringe	$ 8,091
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 45,742**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

IT Project Manager- *Oversees the development, implementation and operation of the care management software across the*

Community Partner Infrastructure Allocation Worksheet

	Behavioral Health Partners of MetroWest LLC (BHPMW) BH CP						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 980,000	$ 1,088,617	$ 914,338	$ 606,844	$ 290,022	$ 4,329,820
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
BHPMW, LLC.	$ 12,500	$ 13,000	$ 11,000	$ 11,000	$ 11,000	$ 6,000	$ 64,500
Advocates	$ 73,867	$ 345,490	$ 267,841	$ 271,313	$ 134,013	$ 119,461	$ 1,211,985
Wayside	$ 6,750	$ 4,320	$ 3,240	$ 3,240	$ 3,240	$ 3,240	$ 24,030
SMOC	$ 27,000	$ 17,280	$ 12,960	$ 12,960	$ 12,960	$ 12,960	$ 96,120
Spectrum	$ 25,875	$ 16,560	$ 12,420	$ 12,420	$ 12,420	$ 12,420	$ 92,115
Family Continuity	$ 24,750	$ 15,840	$ 11,880	$ 11,880	$ 11,880	$ 11,880	$ 88,110
Total Technology	$ 170,742	$ 412,490	$ 319,341	$ 322,813	$ 185,513	$ 165,961	$ 1,576,860
Workforce Development							
BHPMW, LLC.	$ 5,625	$ 10,000					$ 15,625
Advocates	$ 1,093	$ 36,497	$ 19,127	$ 16,173	$ 8,613	$ 3,899	$ 85,402
Wayside	$ 263	$ 8,759	$ 4,590	$ 3,881	$ 2,067	$ 936	$ 20,496
SMOC	$ 1,050	$ 35,036	$ 20,760	$ 15,526	$ 8,269	$ 3,743	$ 84,384
Spectrum	$ 11,006	$ 38,577	$ 17,595	$ 17,279	$ 7,924	$ 3,587	$ 95,968
Family Continuity	$ 963	$ 32,117	$ 16,830	$ 14,232	$ 7,580	$ 3,431	$ 75,153
Total Workforce Development	$ 20,000	$ 160,986.0	$ 78,902	$ 67,091	$ 34,453	$ 15,596	$ 377,028
Business Start Up Costs							
BHPMW, LLC.							$ -
Advocates	$ 35,733	$ 23,070		$ -	$ -	$ -	$ 58,803
Wayside	$ 8,576	$ 5,536		$ -	$ -	$ -	$ 14,112
SMOC	$ 34,304	$ 22,146		$ -	$ -	$ -	$ 56,450
Spectrum	$ 32,874	$ 21,223		$ -	$ -	$ -	$ 54,097
Family Continuity	$ 31,445	$ 20,300		$ -	$ -	$ -	$ 51,745
Business Start Up Costs	$ 142,932	$ 92,275	$ -	$ -	$ -	$ -	$ 235,207
Operational Infrastructure							
BHPMW, LLC.	$76,262	$146,366	$415,324	$280,944	$256,000	$77,390	$ 1,252,286
Advocates	$5,063	$62,884	$158,413	$145,525	$65,859		$ 437,744
Wayside							$ -
SMOC							$ -
Spectrum							$ -
Family Continuity							$ -
Operational Infrastructure	$ 81,325	$ 209,250	$ 573,737	$ 426,469	$ 321,859	$ 77,390	$ 1,690,030
TOTAL INVESTMENTS	$ 414,999	$ 875,001	$ 971,980	$ 816,373	$ 541,825	$ 258,947	$ 3,879,125

Community Partner Milestones Report

Behavioral Health Partners of MetroWest LLC (BHPMW) BH CP

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Development and Adaptation of E.H.R/Care Management System	BHPMW BH CP will be ready to begin using the customized care management software by the go-live date of 6/1/2018.	11/01/17	05/31/18	Testing of the care management software will begin by 3/31/18. By testing, will this involve all your Partner sites? Please add if so.	Testing will be documented on a testing log, evidencing that testing that began by 3/31/17.			Care coordination staff will complete initial training on the care management software by 5/31/18.	Training attendance sheets will evidence that care coordination staff completed training on the software by 5/31/18.		
Technology												
Technology												
Technology												
Workforce Development	Training Expenses	BHPMW BH CP staff will be receive orientation and training by the go-live date of 6/1/2018.	10/01/17	05/31/18	Core training curricula will be developed by 3/31/17. Who is developing the training curricula?	Training materials will be produced by 3/31/17.			Care coordination staff will be trained on the core curricula by 5/31/18.	Training attendance sheets will evidence that care coordination staff completed core training by 5/31/18.		
Workforce Development												
Workforce Development												
Workforce Development												
Business Start Up Costs	Ramp-up Costs	BHPMW BH CP will hire care coordination staff in time to participate in training and be ready to begin delivering CP supports and activities by the go-live date of 6/1/2018.	01/01/18	05/31/18	Recruitment efforts beginning on 1/1/18. Needs to be more specific.	Evidence will include job postings and other recruitment efforts such as job fairs that occurred on or after 1/1/18.			At least one third of the projected year 1 care coordination staffing will be hired by 5/31/18.	A list will be provided of care coordination FTEs filled by 5/31/18, with a calculation of the percentage of the projected year 1 care coordination staff that they reflect.		
Business Start Up Costs												
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Operation Staffing including Fringe	The BHPMW BH CP Program Directgor will be ready to launch the program by the go-live date of 6/1/2018.	01/01/18	05/31/18	The BH CP Program Director will be hired by 3/31/18.	Evidence of hiring will be provided, such as a signed offer letter.			The BH CP Program Director will complete two months of pre- go live employment by 5/31/18.	The HR department will provide confirmation to the Program Director's continued employment, that will be of at least 2 months duration by 5/31/18.		
Operational Infrastructure	Other Operational Expenses	BHPMW BH CP will obtain legal services as needed and execute agreements with ACO/MCOs.	10/01/17	03/30/18	BHPMW BH CP will execute agreements with ACO/MCOs in the North and Central regions by 3/30/17	Signed ACO/MCO agreements will be provided.			n/a- goal will be completed by 3/30/18.	n/a- goal will be completed by 3/30/18.		
Operational Infrastructure												
Operational Infrastructure												

BH Community Partner - Staffing Model

Behavioral Health Partners
METROWEST

Section 7. Program Response
Section 7.3 Initial DSRIP Participation Plan
Revised 12/1/17

A. Executive Summary

BHPMW BHCP five year business plan is founded on longstanding collaborative partners that created an LLC to prepare for health care reform; extensive advanced planning on all aspects of the BHCP model; and knowledge, experience, and investment in health care service delivery reform. BHPMW, LLC will be the Contractor; LLC member agencies Advocates, SMOC, Spectrum and Wayside will be Consortium Entities (CE); and Family Continuity will be an Affiliated Partner (AP). Their combined expertise enables BHCP to provide robust CP supports to many focus populations: Enrollees with SMI, SUD, co-occurring SMI/SUD, co-occurring BH/LTSS, CBFS clients, Enrollees who are homeless, Enrollees involved with the criminal justice system, transitional age youth/young adults, and Enrollees with culturally, ethnically and linguistically diverse backgrounds. The CEs and AP are embedded in the proposed Service Areas and will utilize their experience, locations, continuums of care, and community partnerships to provide all CP supports to these diverse populations therein. Financial success will depend on: centralized contract management; appropriately maximizing care coordination and infrastructure revenue by engaging as many Enrollees as quickly as possible; providing Qualified Activities consistently; managing accurate and efficient billing processes; achieving positive outcomes and a strong DSRIP Accountability Score; and working proactively with ACOs and MCOs on Alternative Payment Methodologies (APM) and sustainability plans.

1. Goals, challenges, and Proposed Solutions

Table 11: Priority Goals
To support Enrollees in improving their health and wellness by effectively providing CP supports and partnering with them to meet their self-defined needs, coordinate and integrate their care across primary care, specialty medical, BH, SUD, LTSS and social services that affect health
To consistently meet EOHHS's expectations and contribute to achieving delivery system reform that results in improved Enrollee outcomes; cost efficiencies; new ways of doing business; and sustainability for the BHCP

Table 12: Challenges and Proposed Solutions
Challenge: # people with BH, SUD and social service needs who do not access needed services and supports; **Solution:** Qualitative and quantitative processes for identifying eligible Enrollees will enable BHCP to outreach and engage them in needed services
Challenge: impact of social needs- housing, financial support, etc.- on people's ability to take care of their health and use services that are available to them; **Solution:** BHCP well positioned to link people to needed social services, many of which are offered by one of the CEs (SMOC)
Challenge: lack of capacity and availability of needed BH and other services; **Solution:** BHCP well positioned to link people to BH and other services in their continuums of care and through robust community partnerships
Challenge: community members lack of knowledge about where and how to access services; **Solution:** BHCP will educate Enrollees and referral sources- ACOs, PCPs, etc.- about how to access services via the BHCP

Challenge: lack of services and supports that are recovery oriented, culturally appropriate, trauma informed; **Solution:** BHCP staff will be trained and CP supports delivered in a recovery oriented, culturally appropriate and trauma informed manner, with use of Evidence Based Practices
Challenge: lack of communication, coordination and integration among service providers; **Solution:** BHCP has developed strategies and will develop protocols to facilitate communication, coordination, integration
Challenge: fragmentation, lack of alignment among service structures, delivery, reimbursement; **Solution:** BHCP will work with ACOs, MCOs, PCPs, etc. to achieve shared outcomes of redesigned MassHealth system
Challenge: inadequate reimbursement methodologies; **Solution:** BHCP will demonstrate value and work with ACOs and MCOs to develop APMs during and after Contract Term

2. Number of Assigned and Engaged Enrollees

BHCP proposes to serve 3500 Enrollees; a five year ramp up plan has been developed.

3. Service Areas

Central- Athol, Framingham, Gardner-Fitchburg, Southbridge, Waltham, Worcester
North- Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn

4. Plan and Timeframes to Operationalize the Community Partner Program

BHPMW has developed a structured plan to operationalize the BHCP program in compliance with the Model Contract. The Implementation Plan and Timeline can be found in the attachments for Section 7.3.F. of this proposal.

Activities early in the Budget Preparation Period will include negotiating BHCP contract and establishing a quarterly meeting and reporting schedule with EOHHS; submitting an initial DSRIP Participation Plan, Budget Report and Budget Narrative to EOHHS for approval; establishing an implementation team and Governing Body Executive Committee; executing agreements with CEs and AP; executing a contract with a care management software vendor; and negotiating contractual agreements with ACOs and MCOs. The next phase during the Budget Preparation Period will involve developing and documenting policies and procedures for BHCP operations; developing Enrollee protections and grievance policies and procedures; finalizing staff recruitment, hiring, orientation and training plans and curricula; hiring key leadership staff; expanding community partnerships and resource databases; finalizing the comprehensive assessment and person-centered treatment plan; working with the care management software vendor to modify the system to meet all BHCP requirements; adopting a formal Continuity of Operations Plan; and establishing accounting and financial management, IT, billing, and reporting systems. The final phase of the Budget Preparation Period will involve successfully completing the EOHHS Readiness Review; hiring and training all staff on the BHCP model, CP supports, EBPs, and care management software; educating and outreaching Enrollees with pre-existing relationships; beginning to recruit potential Consumer Advisory Board (CAB) members; and developing relationships and protocols with PCPs, ACOs and MCOs.

BHPMW Executive Director will be responsible for all Budget Preparation Period activities. BHCP Program Director will be hired in February 2018; manage all program start up activities; and in collaboration with CEs and AP recruit, hire and train staff by May 31, 2018 utilizing a start-up approach consistent with staffing ratios that account for initial volume projections.

Key steps to operationalize the BHCP during Budget Period 1 will include accepting Assigned Enrollees and implementing all CP Supports; continuing to provide extensive staff training; initiating monthly to quarterly BHPMW contract management meetings with each CE and AP to assess and support their performance; convening the Quality Management Committee, developing a QI Plan, and implementing the annual quality initiative; convening the CAB; and

establishing systems to implement all annual deliverables to be met in all subsequent Budget Periods throughout the initial Contract Term. Beginning in Budget Period 3 and increasing in Budget Periods 4 and 5, many activities will focus on sustainability and transition planning.

B. Supporting Populations and Community Engagement

1. Community Connections

The CEs and AP are well connected to the proposed Service Areas through robust community connections that position them to provide CP supports effectively to the focus populations. They collectively offer many of the resources that Engaged Enrollees will need to access, within their own continuums of care, including services for BH, SUD, and co-occurring disorders, LTSS, and resources to address housing and other social needs that affect health. These agencies already have multidirectional collaborations among themselves. They are embedded in these areas through their numerous locations and programs and their extensive partnerships with external community based organizations, advocacy groups, BH and social services, housing/shelter providers, and state agencies. In all Service Areas, they have longstanding relationships with EOHHS agencies - DMH, BSAS, MRC, DCF, DYS, DOC, MCDHoH, and others - through contracts, bidirectional referrals, and collaboration on many initiatives. They have working relationships with ESPs, CSAs, CBFS providers, and DCF lead agencies in all areas and are in these roles themselves in some of them. Table 13 shows CEs and AP with major locations and programs in each Service Area and many current connections. Lists are abbreviated due to page limits; more information is available.

Table 13: Community Connections by Region and Area

Central Region	
Athol	Central Mass. Housing Alliance, Community Health Link, Gardner Visiting Nurses Association, Healthy Start, Institute for Health & Recovery, LUK, Montachusett Opportunity Council, Our Father's House, Salvation Army, The Bridge, UMass Medical Center, Veteran's Inc.
Framingham *CHC= community health center; F= Framingham; Med= medical; MW= MetroWest; RLC= Recovery Learning Community*	**CE & AP locations/programs:** Advocates- F, Marlboro; SMOC-F, Marlboro; Spectrum- F, Milford, Westboro; Wayside- F, Milford
	Colleges: Framingham State University, Mass Bay Community College, William James College
	Medical: E M Kennedy CHC, Genoa and Whittier Pharmacies, Harvard Vanguard Med Associates, Marlborough Hospital, MW Med Center, MW Internal Medicine, Milford Med Center, Natick VNA, Northbridge Med Center, Southboro Med Group, Tri County Med, UMass PCPs
	Police Departments: Ashland, Blackstone, Boxborough, Framingham, Holliston, Hopkinton, Marlborough, Millville, Northbridge, Sherborn, Sutton
	Ashland Decision at Every Turn Coalition, Baypath Elder Services, Career Connections, Council on Aging, Employment Options, Evolve Fitness, F Coalition & Community Connections, Housing Authorities- F & Natick, Marlborough Food Pantry, MCI F, Metro Suburban RLC, MW Center for Independent Living, MW Dual Diagnosis Coalition, MW Legal Services, MW Transit Authority, NAMI MW, Natick Service Council, New England Recovery Center, Partnership for a Skilled Workforce, Programs for People, Recovery Connector, Salvation Army, OUT- MW, Temple Shir Tikva, Tempo Young Adult Resource Center, United Way Call2Talk, YMCA- MW, Northboro
Gardner-Fitchburg	**CE & AP locations/programs:** Advocates- Ayer; Spectrum- Leominster
	Medical: Gardner Visiting Nurses Association, Heywood Hospital, UMass Medical
	Police Departments: Ashby, Ayer, Groton, Pepperell, Shirley, Townsend
	Central Mass. Housing Alliance, City of Worcester, Community Health Link , Eliot Community Services, Healthy Start, Institute for Health & Recovery, LUK, Montachusett Opportunity Council, Our Father's House , Salvation Army, The Bridge, Veteran's Inc., Worcester YMCA
Southbridge	**CE & AP locations/programs:** FC- Whitinsville; Spectrum- Southbridge

	CHNA, Dr. Pathack, Harrington Hospital, Riverside Community Care, Venture Capital, YOU, Inc.
Waltham	**CE & AP locations/programs:** Advocates, Spectrum- Waltham; Wayside- Waltham, Watertown
	Police Departments: Newton, Watertown
	Bristol Lodge Men's Shelter, J. P. Smith Community Health Center, North Charles Center for Addiction, Children's Room Arlington, Waltham Partnership for Youth, Waltham Alliance to Create Housing, Waltham YMCA, Watertown Social Services, Watertown Youth Coalition
Worcester *(W= Worcester)*	**CE & AP location/programs:** Advocates, FC, SMOC, Spectrum- Worcester
	Colleges: Anna Maria College, Becker College, Assumption College, Clark University, Quinsigamond Community College, UMass Memorial Medical School, Worcester State University
	Medical: AIDS Project Worcester, Health Awareness Services, E. M. Kennedy Community Health Center, Pernet Health Care, Reliant Medical Group, UMASS Medical Center and Primary Care
	Abby's House, Adcare, Ascentria Care Alliance, Central MA Housing Alliance, City of Worcester, Community Healthlink, Devereux, Eliot Community Services, Everyday Miracles Peer Recovery Program, Healthy Start, Institute for Health & Recovery, Latin American Health Alliance, Lazarus House, Learn to Cope, LUK, Massachusetts Organization for Addiction Recovery, Salvation Army, The Bridge, Veteran's Inc., W County Jail, W Probation, W Learning Center, W YMCA
North Region	
Beverly	Beverly Hospital, Lahey Behavioral Health
Gloucester	Action, Inc., Addison Gilbert Hospital, Cape Ann Adult Day Treatment Center, Compass, Gloucester Housing Authority, Lahey Behavioral Health, Open Door food pantry, The Police Assisted Addiction and Recovery Initiative, Rose Baker Senior Center, Wellspring House
Haverhill	**CE & AP locations/programs:** Spectrum- Haverhill
	Arbour Counseling, Lahey Behavioral Health CSA, Holy Family Hospital at Merrimack Valley, Emmanuel House, Emmaus House, Guardian Health, Haverhill Housing, Haverhill Clubhouse, Northeast Family Institute, Pentucket Medical, Ruth's House, St. Vincent de Paul
Lawrence	**CE & AP locations/programs:** FC- Lawrence
	Greater Lawrence Family Health Center, Lahey Behavioral Health, Lawrence Technical High School, Lazarus House Ministries, New Beginnings Peer Recovery Center
Lowell	**CE & AP locations/programs:** SMOC, Wayside- Lowell; Advocates- Acton, Lincoln, Littleton
	Police Departments: Dunstable, Littleton, Westford
	Community Team Work Inc., DTA/CTI housing, Lowell Community Health Center, Lowell House, Mental Health Associates, South Bay SOAP, UTech Young Adult Resource Center, Youth Build
Lynn	**CE & AP locations/programs:** Spectrum- Saugus
	BayRidge Hospital, Bosnian Coalition, Congolese Alliance, Lynn Community Health Center, New American Center, Refugee and Immigrant Assistant Center, Saugus United against Substance Abuse
Malden	**CE & AP locations/programs:** Wayside- Malden
	ABCD Mystic Valley Opportunity Center, Eliot Community Services, Greater Malden Behavioral Health, Housing Families, Malden Recreation Department, Malden Teen Center, Malden YMCA
Salem	**CE & AP locations/programs:** FC- Peabody
	Salem Middleton House of Corrections detox, Lahey BH Danvers & Salem, Lahey Peabody
Woburn	**CE & AP locations/programs:** Advocates, Wayside- Burlington
	Burlington Youth & Family Services, Edinburgh Center, Lahey Medical Center, Lahey Winchester Hospital, Lexington Human Services, North Suburban YMCA, Woburn Council for Social Concern

2. Growing Community Connections

BHPMW BHCP will target specific gaps, mostly related to primary care, BH and social services, in each Service Area, particularly Athol, Beverly, Lawrence, Lynn, Malden, Salem and Southbridge. There are disparities in resources across these communities; the BHPMW will use

its experience in helping develop new resources and collaborations. Two groups have been identified that offer many supports in these areas: Catholic Charities and Jewish Child and Family Services. The CEs and AP will use their relationships in the provider community to reach out.

3. Keeping Staff Current with Community Connections

Staff will keep current through a services database of all the CE and AP services already created by the BHPMW, and through ongoing resource identification and information sharing, with a dedicated Triage/Resource Coordinator at the BHPMW.

C. Community Partner Supports and Activities

The BHPMW BHCP will maintain Contractual Agreements with ACOs and MCOs that operate in its Service Areas that require the BHCP to perform the following CP supports and activities with protocols informed by the National Quality Forum (NQF), Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report, Washington, DC: NQF; 2010. BHPMW will triage Assigned Enrollees to CEs and AP to provide all CP supports and activities to the assigned members. Each will accept Assigned Enrollees and provide CP supports in the proposed Service Areas as summarized in Table 14, using their expertise to deliver CP supports to Enrollees with BH, SUD, and/or LTSS needs; medical complexity; and those who are homeless, transitional age youth/young adults, and/or involved in the criminal justice system.

Table 14: CEs and AP that will provide CP Supports in each Service Area

Region	Service Area	Advocates	Family Continuity	SMOC	Spectrum	Wayside
Central	Athol			X		
	Framingham	X		X	X	X
	Gardner-Fitchburg	X		X	X	
	Southbridge		X		X	X
	Waltham	X			X	X
	Worcester	X	X	X	X	
North	Beverly		X			
	Gloucester		X			
	Haverhill		X		X	
	Lawrence		X			
	Lowell	X		X		X
	Lynn		X		X	
	Malden					X
	Salem		X			
	Woburn	X				X

In providing all CP supports, BHPMW BHCP will be guided by the ten principles of Wraparound: family voice and choice, team-based, natural supports, collaboration, community-based, cultural competence, individualized, strengths-based, persistent, and outcome-based. Advocates, Family Continuity, SMOC and Wayside all have training and experience in this Evidence Based Practice (EBP) through their provision of Children's Behavioral Health

Initiative (CBHI) services for the past eight years. Wraparound principle and practices will be included in the BHCP training plan.

1. Outreach and Active Engagement

BHPMW BHCP will develop, implement, maintain and adhere to a protocol, to be approved by EOHHS, for outreach and active engagement of Assigned Enrollees. The protocol will include core outreach and engagement activities that will be implemented with all Assigned Enrollees and with specific strategies for hard to reach members. It is expected that the level of effort will vary, as some will be easier to reach and/or easier to engage than others. Staff will be proactive and persistent while also respectful of privacy rights so they do not alienate the people they are trying to engage. BHPMW BHCP will work with ACOs to shape the content of the referral information that they provide to facilitate these efforts. It will be critical to get accurate contact information for the member and their providers, and guardianship information will be important for some.

a. Strategies for outreaching to and engaging with Assigned Enrollees

BHCP staff will conduct at least one outreach activity to each Assigned Enrollee within 30 days of the enrollee's assignment and at least one face to face visit within the first 3 calendar months of assignment. A flag will be put in the care management software to alert BHCP if activities have not been completed as these timeframes are approaching. BHCP plans to exceed these requirements in terms of both the number of outreach activities and the timeframe in which outreach activities are initiated. In the first year of operation, BHCP will be in the outreach and engagement phase with a large volume of enrollees. The CEs and AP's collective experience is that this stage is labor intensive and time consuming; outreach and engagement are critical interventions and as important as the services themselves in the care management process.

BHPMW will devote all resources to outreach and engagement during the first year to maximize the ability to outreach, engage and enroll as many members in BHCP as quickly as possible. The Care Coordinators (CC) and Clinical Care Managers (CCM) will conduct outreach and engagement activities with specific training and support from the BHCP program managers and quality managers at each CE and AP. They will also rely on the Peer Specialists, Recovery Coaches and Family Partners on their CP teams, appropriate to the population they are engaging, to be active in outreach and engagement. Peer Support is an EBP that is successful as the primary relationship that demonstrates mental health recovery is possible – that people who have spent decades in hospitals and community mental health treatment due to a serious psychiatric diagnosis such as schizophrenia, can and do recover. Peer Support will be used throughout the provision of all CP supports and activities. Another staffing strategy will be employing staff reflective of the population racially, ethnically and linguistically, which can also be important during the outreach and engagement phases. BHPMW BHCP Director of Population Health and Triage/Resource Coordinator will manage Enrollee assignments efficiently and will train CP teams on outreach and engagement best practices.

As community based providers, the CEs and AP know their communities and are adept at being able to locate people, meet them, offer assistance, be available and work with them in an ongoing manner. BHCP will proactively employ many specific strategies for outreach that have been successful in the agencies' care management and other programs. It is anticipated that some Assigned Enrollees will be known to the CEs and AP who may know how to reach them. Whether known or not, staff will utilize any available contact information - phone numbers, addresses, current and last known providers, and places the members frequent - from the referral sources, members' PCPs, other known providers, and internal records if they were previously

served by CEs or AP. MCOs may have this information as they often have longitudinal information on members. CCs will call any phone numbers obtained. One advantage is that if members have cell phones, they stay with them wherever they go. However, people are often worried about the number of minutes available, making it less likely they will answer their phones, return calls, or talk for long. Many people don't listen to voice mails. Texting and emailing mitigates some of these barriers. CCs will arrange free cell phones thru Safe Link-Massachusetts, with 250 monthly minutes, which will enable Enrollees and staff to keep in touch.

CCs will use internet search engines and social media sites to try to find people and their contact information, and communicate with them electronically. CCs will go to locations at which the Enrollees are known to currently reside, and any other addresses on record, and conduct face to face visits if staff locate them. If they are not there, they may leave a note. CCs will mail letters, asking members to contact them, and contact family members and significant others if they have their information and current releases on file, if the members had been served previously.

If members have primary care, BH, and/or other providers, CCs will provide written materials and engage those providers to talk with the members when they see them, to educate them about BHCP, encourage them to contact us or get consent to give us their contact information. Staff will conduct face to face visits with Enrollees in these providers' settings, if possible. In order engage PCPs in the process of delivering CP supports, BHCP will develop brief handouts and begin visiting PCPs before the contract start date to educate PCPs and their designees and begin to develop relationships and protocols for their participation on the Care Team (CT) and for Enrollee engagement, assessment, treatment planning, and ongoing care coordination. It will be important for BHCP to demonstrate to the PCP how the CP, and the care integration we can achieve together, can be helpful to them and their patients. This will ultimately be the most successful way to engage them in this process. BHPMW will outreach to ACOs to work collaboratively in engaging their PCP networks.

CCs will conduct face to face visits with members in shelters, hospitals, detoxification programs, and other locations. They will go to places that specific members or many of the members they serve generally frequent: recovery connections/young adult/family/employment training resource centers, re-entry programs, drop in centers, food pantries, WIC programs, fast food restaurants and public libraries. BHCP will develop Business Associate Agreements (BAAs) with entities, such as shelters, that the BHCP is likely to work with frequently to locate, outreach and engage members. In all these outreach efforts, staff will abide by privacy rules and principles of respect.

BHCP will work closely with the Emergency Services Programs/Mobile Crisis Intervention (ESP/MCI) providers as many high-risk members are known to them, and they may have contact with people staff are trying to locate, particularly when they present in a hospital ED setting. BHPMW BHCP is well positioned to coordinate with ESP/MCIs, given that Advocates and subcontractor Wayside operate the ESP/MCI in the MetroWest area which includes portions of both the Central and North regions in which BHPMW is bidding. Advocates ESP/MCI and the CEs and AP have relationships with the other ESP/MCI programs in the proposed Service Area.

Engagement Strategies

Once outreach efforts are successful and BHCP staff have contacted the Enrollee, the overarching engagement strategy will be to start "where the person is." Staff will be persistent while respectful; the approach will be culturally responsive and trauma informed, in the language of the person; and staff will utilize motivational interviewing (MI), an EBP and a core component of many EBPs and emerging best practices. BHCP will use MI in conducting many

of the CP supports and activities to assess participants' readiness for change and engage them in the process. CCs will ask members what would be helpful to them and respond to whatever needs they identify. Someone's initial concern may be needing a ride to a medical appointment or food pantry or help applying for entitlement benefits. Enrollees often initially say they don't need anything: staff have learned to ask if it's okay to continue to call them at an agreed upon interval, and most members accept. Members eventually tell us "I got this letter I don't know what to do with", or "I have this appointment I am worried about", or "I need to get my prescriptions filled." Staff will develop trust by taking their priorities seriously and working on what they feel they need. This illustrates how care coordination activities begin during the engagement process. CC's will start providing whatever care coordination and other assistance the member will allow even before they sign participation forms. During this period, CCs will integrate information about the benefits, design and purpose of CP supports and the process for engaging in the BHCP. CCs will also provide opportunities for the Enrollee to opt out of receiving CP supports or request a different CP.

For populations or specific Enrollees who may be particularly hard to reach, BHCP will employ all the strategies above, in more intensity and/or for a longer duration than with other members. Additionally, staff will use the approaches outlined below for the following focus populations.

Strategies for outreaching to and engaging members who are homeless and hard to reach

Outreach and engagement strategies with individuals experiencing homelessness usually start with staff going to shelters, particularly those where known members tend to stay, especially if they are known to the CEs and AP or staff get this information from their providers or others. Because shelters close during the day, CCs will go to places where people are during these hours - food banks, lunch programs, drop in centers, libraries, and other public places. To go to shelters, BHCP staff will work in the late afternoon and evening. SMOC operates shelters in the proposed Service Areas in the Central and North regions, so BHCP will have good access to members in those settings. CEs and AP work with closely with police; individuals who are homeless or otherwise hard to reach are sometimes known to them and/or of concern to them. The CEs and AP have good relationships with numerous police departments in the proposed Service Areas.

b. Strategies for outreaching to and engaging assigned enrollees diagnosed with SUDThe most effective strategy is to go to Acute Treatment Services (ATS, aka, detoxes) and other 24 hour levels of care (LOC) for people diagnosed with SUD and contact them while they are still in those settings. Advocates has established protocols with three local ATS programs to identify and contact members in a HIPAA compliant manner before they are discharged from these settings. BHCP staff will work with residential treatment programs and sober houses. Of note: three of the providers in BHPMW BHCP operate some of these programs in the proposed Service Areas, so BHCP will have good access to members in those settings. Spectrum operates many outpatient clinics providing Medically Assisted Treatment (MAT) where some of these members attend services daily. CCs will go to Structured Outpatient Addictions Programs (SOAPS), alcohol recovery centers and young adult resources centers which some members attend, mostly during the day. Advocates, SMOC and Spectrum employ peer recovery coaches, and some of these agencies have CCs who have lived experience with SUD, resources that will also be used in BHCP, as these staff are often instrumental in engaging members with SUD.

c. Process for obtaining and documenting agreement to participate in CP Supports

Once staff have forged initial alliances and have begun to help Assigned Enrollees with their felt needs, Enrollees are usually willing to sign the paperwork necessary to continue receiving the care coordination services staff are offering. CC will ask the Enrollee to sign a participation form; explain the purpose as confirmation that the member agrees to participate in BHCP; explain the Protected Information (PI) that BHCP will obtain, use and share; and request written authorization to use and disclose PI as needed during the provision of these services. CCs will provide the participation form and consents in languages other than English; enter this documentation in the care management software; and give copies to the member. The participation form will be executed before initiating the Comprehensive Assessment. Within 5 business days, BHCP will assign a CC, usually the one who conducted outreach and engagement with the member.

2. Comprehensive Assessment and Person-Centered Treatment Planning

Person-centeredness is embedded in the BHPMW, CEs and AP's values and philosophies. Since person-centered planning and service delivery has become a priority in the BH field, all have integrated these concepts into staff training, program protocols, and quality improvement programs. Person-centered planning, an EBP, will be included in the BHCP's training plan. Since BHPMW BHCP's approach to outreach and engagement starts where members are at, the natural next part of the process is working with them to understand their needs, goals, and barriers to achieving those goals. CCs will engage Enrollees in articulating this through the assessment and treatment planning process and give input in a transparent way.

a. Process for completing comprehensive assessment and ensuring Enrollee participation

For each Enrollee who signs a participation form, CCMs and CCs will complete a Comprehensive Assessment at least within three calendar months of the Assigned Enrollee's assignment to the BHCP and annually. Subject to approval by EOHHS, BHCP will use a tool that includes an assessment and documentation of all domains specified in the Model Contract. BHPMW's proposed assessment is attached. It will be built into the care management software that BHPMW BHCP will purchase and collaboratively configure with the vendor.

BHCP will ensure that Engaged Enrollees participate in the assessment process by completing the assessment collaboratively with them. They will meet, have a conversation about the assessment questions and complete the assessment form together. As illustrated in BHPMW comprehensive assessment tool, in the attachments for this section, CCs will share the information they have been given about the member from the referral source and ask for verification, clarification, and additional data. This approach is used to be transparent with members about what information BHCP already has and to enable them to not repeat information that they or others have already provided. As also reflected in the assessment tool, staff will state such information as needs, goals and barriers, in person-centered language, e.g., "I want to get stable housing." This person centered approach engages the member in feeling that the assessment and plan is theirs.

The process also includes incorporating collateral information into the assessment, with the full knowledge and consent of the Assigned Enrollee. Using authorizations obtained when the Enrollees signed participation forms, and additional consents if needed, CCs will contact their providers including primary care, specialty medical, BH, and others. They will reach out to them via phone, email, mail or fax to request information and offer input into the assessment. CCs will engage with them to whatever extent they are available, by sending information, obtaining records, and/or having a discussion to share collaborate and coordinate care. The easiest providers to contact are those within our own agencies when members are receiving other

services therein. It is expected this will be the case for BHCP Enrollees who have pre-existing relationships with the BHCP. If the Enrollee's providers are at other agencies, CCs will be persistent in calling and emailing them. CCs will generally request a call back to introduce themselves, explain BHCP role as part of the CT and initiate ongoing collaboration. They will ask for input into the assessment and treatment plan including goals and needed services.

In the CEs and AP's collective experience, the most challenging attempts to get input into the comprehensive assessment and forge ongoing communication has been with medical providers. It tends to be difficult to get the PCPs or their designees to return calls. A specific strategy that has been helpful is accompanying members to primary and specialty care appointments, particularly when they are medically complex. The medical providers then know the CCs and are more likely to return or initiate calls to coordinate care. Another effective approach is nurse to nurse communication. We look forward to working with PCP designees in the ACO model.

An additional strategy to engage PCPs will be utilizing data to identify practices that have significant numbers of BHPMW's BHCP Engaged Enrollees on their panels. BHCP will use RN, CCM and CC staff to visit the practices, introduce BHCP program, and develop RN to RN or RN to NP relationships and communication. BHPMW will also collaborate with the ACOs to assist with brokering communication, information sharing and integration among the CP, PCP and specialty medical providers. The initial goal will be to get input into the comprehensive assessment and person-centered treatment plan and begin to establish ongoing collaboration.

Once CCs obtain information and input from PCPs and other collaterals, they will share that information with the Engaged Enrollee and incorporate it into the assessment. The member's CC will have primary responsibility for completing the comprehensive assessment with involvement from others on the CP team, under the supervision of a CCM who meets the required credentialing criteria. CCMs will have direct contact with Enrollees as indicated based on their needs, the complexity of the assessment, and the level of support needed by the CC. The CC will document the assessment tool in the care management software. The RN on the CP team will review each Engaged Enrollee's medical history, medical needs and medications. The RN or CCM on the CP team will provide final review and approval of the entire assessment. In most cases, the member's CCM, who supervises the CC who completed the assessment, will conduct this final review and approval. CC will give a copy of the assessment to the member, in languages other than English or other formats as needed.

An exception to completing the initial comprehensive assessment within three months will be if an existing comprehensive assessment was completed with the Enrollee within three calendar months prior to assignment to BHPMW BHCP and includes all required domains. If so, CC and Enrollee will review the assessment and update it as needed, ensuring all domains are included, and if not CC and member will complete the missing assessment sections. In all cases, CC will complete a new comprehensive assessment with the member at least annually.

b. Process for developing person-centered treatment plan

1) Ensuring Enrollee participation

CC will meet with the member to collaboratively "put together a plan for our work together." Goals will be written in person centered language, e.g., "I want to get a new psychiatrist", "I need a safer place to live." CC will elicit manageable steps to achieve the goals and incorporate the member's preferences, needs and cultural considerations in developing the plan, using their language, translating documents and providing other formats if needed. The CT, including guardians if applicable, will be involved in developing the plan, using similar strategies described above for involving them in the assessment. The plan will document the stakeholders

to whom it is sent, including the PCP, other CT members, and the ACO or MCO, as authorized by the member. CCM will supervise plan development and be directly involved as needed.

2) Process for documenting the person-centered treatment plan

CC will document the person-centered treatment plan in the care management software that BHPMW BHCP will purchase. The format will contain all the domains and meet all the requirements specified in the Model Contract including the results of the assessment, services including Flexible Services, goals, barriers, contact lists and reassessment dates. The CEs and AP have extensive experience with crisis planning which will also be part of the assessment and treatment planning process. As evidenced by the attached comprehensive assessment form, CC will ask Engaged Enrollees if they have crisis plans and/or want plans. The Crisis Plans will be developed along with the person-centered treatment plan and will include: strengths and resources; description of what happens when the member is doing well and not doing well; strategies that do and do not help, e.g., coping skills, wellness tools, accessing services, informal supports; contact information for the ESP/MCI and all supports and service providers identified as resources in a crisis; referred facilities if the member needs more intensive LOCs; the stakeholders to whom the plan will be sent; and the member's signature approving the plan.

3) Process for updating the person-centered treatment plan

All requirements will be met relative to updating treatment plans at least every six months and when the Engaged Enrollee's status changes significantly. CC will meet with the person, explain the need to update plan, and review: the current plan, what has changed, what has and has not worked, and the status of client's goals - what's been achieved, what has not, what should remain/change/be added. CC will also reassess the person's health status and document the recommendations for follow-up. Enrollees will receive copies of the updated plan.

4) Process for ensuring PCP or designee approve the person-centered treatment plan

BHPMW will work with ACOs, MCOs and PCPs to develop protocols for obtaining approval of the plans by PCP or designee. Beginning with the outreach and engagement phase, BHCP staff will have developed relationships and educated PCPs about BHCP. PCPs and designees will also have been involved in giving input into the assessment and treatment plan and will be aware that the treatment plan will be coming to them for approval. It is anticipated that there may be a need to familiarize PCPs about the person-centered approach. PCPs could request goals or services to be included in the plans to which members have not agreed. If so, staff will educate the PCPs about the Enrollees' visions for the plans and talk with the Enrollees about the PCPs' recommendations.

Logistically, CCs will email or fax the treatment plan to the PCP office; request approval and give options - sign and send back, email or call with approval, or whatever works for the individual PCP or designee and complies with MassHealth's requirements. Ideally, BHCP will work with high volume PCPs to develop protocols that work for those practices. BHCP will identify their PCP designees and develop relationships with them in advance, so they are familiar with the process, know the treatment plans are coming, and will be ready to follow the protocol the BHCP has worked out with their practices. BHCP may assign a CP team member to a high-volume PCP to go to the office weekly to obtain approval of treatment plans. A similar strategy could be working with large ACOs in the proposed Service Areas to develop protocols with large PCP practices. BHPMW BHCP will strive to complete the assessment and treatment plan within two months of initial assignment to allow one month to obtain PCP approval and submit a "Person Centered Treatment Plan Complete" Qualifying Activity by the end of the third month.

3. Care Coordination and Care Management

Under the supervision of the CCMs and with their direct involvement when indicated, CCs will be responsible for forming and operating a Care Team for each Engaged Enrollee. BHPMW BHCP will ensure that all requirements are met for the CT and the overall provision of care coordination and care management supports. The CEs and AP have substantial experience in convening Care Teams and providing care coordination and care management services through Wayside's role as a CSA and all the providers' care coordination contracts.

a. Stakeholder and Care Team (CT) identification

Continuing a person-centered approach, the Engaged Enrollee will "be in the driver's seat" in developing the CT. CC will engage the Enrollee in identifying all involved stakeholders and determining who will be invited to participate in the CT. CC will have already worked with the Enrollee and others to list all stakeholders in the comprehensive assessment, as well as those who will be involved with the member going forward in the person-centered treatment plan and crisis plan. CC will review these lists with the Enrollee to ensure all stakeholders are identified and consider which of them will be included in the member's CT. Enrollees will be asked who they consider to be on their current CT, if they perceive themselves as having teams, and who they would like to be on them going forward. CC will educate the Enrollee about contractually required stakeholders included on the team and why their participation is important; the CC will request consent to include them. CT will vary based on the Enrollee's needs; the types of expertise, services and supports needed; and the person's preferences.

While at each Enrollee's discretion, it is broadly envisioned that CTs will include the Engaged Enrollee, informal supports such as family members, guardians, advocates, friends, neighbors, faith based organizations, cultural groups, and other community resources; and formal supports including PCPs or PCP designees, other medical providers, state agencies, BHCP CCMs and CCs, and social services agencies. During the ongoing care coordination and care management process, as CCs work with members, get to know their networks, and facilitate linkages to new providers, state agencies, and other supports, they will keep track of those contacts. While a goal will be a consistent core group of CT members for each Enrollee, the team will be a fluid, evolving set of stakeholders who can support a member over time, as needs fluctuate.

b. Information exchange with stakeholders

For the CT to coordinate and integrate care, collaborate, and support the Enrollee effectively, information exchange is necessary. CCs and the Enrollees will discuss the nature and purpose of sharing information with the team in a completely transparent way so they can make informed choices about the content of information to be shared and with which CT participants. CCs will obtain member consent and follow HIPAA compliant procedures. BHPMW BHCP will execute BAAs with entities with which information will be exchanged frequently, as appropriate.

c. Care Team organization and roles

BHPMW will create a form letter to invite stakeholders to participate in CTs. CC will mail or email the letter to the stakeholders that the Engaged Enrollee wants to include on the CT. The letter will contain: Engaged Enrollee's name, stakeholder's name, proposed role on the CT; information about BHCP program, role of the CT and the treatment plan; points of contact and involvement participants should expect. It will request confirmation that the recipient will participate in the CT. BHCP will work with ACOs and MCOs to leverage the participation of CT members, particularly medical providers, initially and ongoing. It may be helpful to specify information about how stakeholders can bill for time spent participating in CT activities.

CC will work with the Engaged Enrollee and CT members to identify each participant's role on the team, appropriate to licensure or training and relationship to the Enrollee. Many roles will have been defined in the treatment plan in terms of services and supports a given CT member will provide. Generally, all CT members' roles will be to bring information to the team; utilize their knowledge and relationship with the person to support and engage them; give input and suggestions; and accept and implement follow up tasks. There may be CT members who participate more actively, depending on the Enrollee's needs, while other CT participants may play a less active role in exchanging information and being available to get more activated if needed.
CC will document the names, contact information and role of each CT member.

Role definition will be particularly important when Enrollees are engaged in other care coordination supports, such as state agency caseworkers or ACO and MCO care management programs. To avoid duplication, BHCP will work with the Enrollees and the other care coordination resources to define roles and responsibilities in a manner that best supports the Enrollees, respects stakeholders' roles and contractual obligations, and achieves efficient, effective care management.

d. Process for ensuring effective ongoing communications across all stakeholders

BHCP staff will facilitate communication among and coordinate with the Engaged Enrollee, the PCP, and other providers who serve the Enrollee including Recovery Support Navigators, CBFS providers, LTSS providers, EOHHS agencies and others to promote service delivery coordination and improved outcomes. Some of these stakeholders will participate in the CT and CC will be responsible for ongoing communication with them. The purpose, content, frequency, intensity and mode of this communication will vary based on Enrollee needs. There will be ongoing communication with all Enrollees' CTs through phone contact, mail and email. Some Enrollees' teams will hold team meetings - face to face, virtual, or telephonic. If CT members cannot participate in a meeting or other contact, CC will obtain their input prior to the meeting and share the outcome with them. Communication methods will vary based on the Enrollee's level of need and acuity, the nature of the communication, e.g., simple information sharing vs. the need to revise the Care Plan due to a significant change, and/or the Enrollee's and CT's preferences, all of which will vary over time. In addition to communicating with the CT, CC will communicate with other stakeholders as indicated. All communications will be done in a transparent manner with the Enrollees, with their consent, and following HIPAA compliant procedures. BHCP's care management software will help manage communications, particularly among the CEs and AP that will utilize it, as may other technology and the use of the Massachusetts HIway.

Support for Engaged Enrollees with LTSS needs

BHPMW BHCP will be well positioned to provide CP supports to Engaged Enrollees with BH and LTSS needs given that one of the CEs, Advocates, has extensive experience with the various LTSS focus populations and provides LTSS services. As a BH health home for CCA OneCare, Advocates care management team facilitates access to LTSS services for those members and works regularly with LTSS providers. The agency is part of an application to serve as an LTSS CP and will have an integrated team providing BH and LTSS CP supports. This CE will consult with the other CEs and AP around supporting members assigned to them with LTSS needs. The BHCP will ensure that CCMs and CCs are trained in LTSS services, programs and providers. Another strategy will be efforts to hire CCMs and CCs with LTSS experience.

For BHCP Engaged Enrollees with LTSS needs, BHCP will facilitate and coordinate LTSS services. CC will educate them about options for LTSS services, programs and providers during the development of their person-centered treatment plans. They will document the choices presented to the members and they will offer at least two providers for consideration. CC will then engage Enrollees in selecting the services and providers they need and want and arrange linkages to those services. CC will encourage Enrollees to include LTSS providers in the CTs and CC will ensure they are communicating with LTSS providers along with all other stakeholders. Given that these BHCP Enrollees will have specific needs that differ from other BHCP Enrollees, CCMs will tend to be more involved in supporting them along with CCs.

Activities to support the treatment plan and timely access to all services

BHCP staff will conduct all necessary activities to support the Enrollees' person-centered treatment plans and ensure that they have timely and coordinated access to all needed services and supports identified therein. One activity will involve CC explaining PCP, specialist and other provider directives to the Enrollee that may have emerged during appointments and/or as part of the comprehensive assessment and treatment planning processes. CC will educate members about the importance of following up on the advice of PCP, specialty medical, BH and other providers; ensure they understand the recommendations; assist with clarifying any questions; engage them in deciding upon a course of action; assist with appropriate follow up; identify and resolve any barriers with adhering to recommendations; and ensure transportation.

BHCP staff will be trained on shared decision making skills, an EBP used in clinical care to increase the Enrollee's participation in their healthcare and related decision making. Prior to meetings with PCPs and other providers, CC will help Enrollees prepare their questions, concerns, needs, and requests to increase the likelihood that they feel part of the decision making that occurs during those visits and have ownership of the resulting plan. BHCP will give CP staff tools to help them monitor Enrollees' medical conditions and compliance with providers' recommendations. BHCP training plan includes community health worker competencies. BHCP will also engage members in health and wellness activities to support their engagement in their health and follow through on provider recommendations.

Care reminders; scheduling and keeping appointments

BHCP's care management software will include a solution for care reminders. CCs will enter Enrollees' appointments into the system and it will generate appointment reminders to the CC. CP staff will make reminder calls to Enrollees. The goal is for this system to send care reminders to Enrollees telephonically and/or electronically, using alternative formats if needed. CCs will actively assist members in scheduling all services and supports identified in their treatment plans. They will involve Enrollees in selecting providers and scheduling appointments at days, times and locations that are convenient to them. CCs and Enrollees will decide if there is a need for CC to accompany the person to certain appointments. If not, CC will identify transportation options, if needed, using both formal and informal resources. CCs will provide transportation when needed, particularly early in the Enrollee's engagement in BHCP, and will work toward accessing other transportation such as The Ride and PT1 forms or using public transportation such as the MetroWest Regional Transit Authority. After appointments, they will follow up to confirm attendance, discuss the outcome and assist with follow up. In cases of non-attendance, CCs will determine the reasons, reschedule and support the member in following through. BHCP will ask ACOs to help engage their PCPs and other providers to share information when people miss appointments so staff can be aware when follow up is needed.

Medication adherence

BHCP staff will confirm with Engaged Enrollees that they are adhering to medication recommendations from all prescribers. When meeting with members, CC will ask how they are doing with their medications; assess if education is needed; obtain answers to any questions or concerns; determine if there is an indication for BHCP RN or a home care nurse to be utilized short term to provide education, set up systems to manage medications, and conduct teaching; and assess the need for medication dispensing devices or prepackaged medications. They will explore other barriers, such as side effects, or the member disagreeing with the prescribed medication regime. If so, CC, CCM or RN will facilitate the Enrollee talking with the prescriber, addressing the concerns, and supporting the member in their decision making. Staff will use shared decision making skills to assist Enrollees in preparing for discussions with their prescribers, which can help to achieve a medication regimen that the member will support.

4. Care Transitions

BHPMW BHCP will meet all requirements related to managing care transitions, beginning with activities prior to the Engaged Enrollee's inpatient discharge or other change in treatment setting.

Discharge planning prior to discharge or change in setting

BHCP will be involved in all care transitions including medical, BH and SUD admissions and other types of transitions in care. Internal mechanisms will be developed to facilitate awareness of care transitions through ongoing communication with Engaged Enrollees and service providers within the CE and AP agencies as well as other involved stakeholder such as state agencies. BHPMW is considering developing an event notifications system among the five CEs and AP which would include information about admissions from Advocates ESP/MCI, Spectrum ATS and other programs. BHCP's effectiveness in managing care transitions will also be dependent upon external systems - ACOs, MCOs, and the state's planned event notification system - developing a seamless system for notifying CPs of admissions and discharges. ACOs and MCOs can also be helpful in ensuring that inpatient and other treatment settings understand BHCP's role including involvement during the admission and discharge. BHCP's effectiveness further depends on being notified as close as possible to the time of admission so staff can be involved with the member during the admission, have early awareness of the anticipated discharge date, and give input into scheduling the discharge planning meeting. This will increase the effectiveness of the discharge plan, the Enrollee's buy-in and the positioning of the BHCP to facilitate the transition in care. BHCP staff will add value to the process through their relationships with the members and ability to help engage them in developing discharge plans that will work for them.

Ensure member of CP team is present at discharge planning meetings

Logistically, BHCP will learn of an admission of an Engaged Enrollee. CC or CCM will contact the facility's social worker; introduce themselves and their roles; ask them to obtain a release of information from the member and call us back; or, CP staff could visit the Enrollee and ask for a release. Facilities may or may not confirm that the Enrollee is there. The MCO or ACO may have to inform the facility that the person is enrolled in a specific BHCP, give them BHCP's contact info and expect the facility to call the CP to involve us in discharge process.

BHCP will ensure that a CP team member is present at the discharge planning meetings, as appropriate, in coordination with the Engaged Enrollee and the ACO or MCO. Every effort will be made for the person's own CC to attend. Alternatives will be CCM assigned to the member, who supervises the assigned CC; another CC on CCM's team; or a CC or CCM on another CP team. The goal will be to attend face to face but if necessary staff will request telephonic participation. This may be warranted by the distance to facilities and the possibility that multiple

discharge meetings or other major commitments with Enrollees could occur on the same day. It will be helpful if MassHealth, ACOs and MCOs prepare facilities of the need for flexibility around the mode of participation in discharge meetings and giving as much advance notice as possible about the scheduling of the discharge planning meeting, increasing the likelihood BHCP and other CT members will be available to participate.

Another contribution BHCP can make is engaging family members and significant others, with appropriate consent, about how to best support Enrollees during the transition; assessing if the environment will support their return to home and community; educating them about revised care plans; and preparing the environment for Enrollees' return. Involving the CP Teams' Peer Specialists/Recovery Coaches/Family Partners and care coordinators who are persons with lived experience and coordinating these efforts with state agency staff can be helpful in supporting Enrollees, families and significant others.

Follow up, accessing services on discharge plan, and ensuring attendance

BHCP will follow up within three business days of an Engaged Enrollee's inpatient discharge or change in treatment setting. Staff will conduct a face to face visit, using that same algorithm as above for who would conduct the visit, and document if a visit was offered and the Enrollee preferred not to meet within that timeframe. Staff will work with the Enrollee to update the person centered treatment plan and crisis plan, incorporate any new needs, goals, services and supports from the discharge plan; and coordinate clinical and support services to implement the discharge plan and revised treatment plan. These activities - linking members to needed resources, scheduling appointments and facilitating follow up - are continuous BHCP functions. CC will update the ACO or MCO, through ongoing communication across stakeholders and through processes the BHCP develops for this purpose with the ACOs and MCOs.

CCs will assist Engaged Enrollees who are referred to other levels of care, care management programs, or other providers in accessing them. Staff will assess what assistance is needed, considering how new the services or providers are to the members, how invested the members are in them, and how independent they are in attending appointments. When indicated, such as if the Member has been referred to a new service at an unfamiliar provider and is unsure about their level of investment or comfort in attending the appointment alone, BHCP staff will be more involved. CCs will conduct warm handoffs and share information with newly involved providers, with member consent and as appropriate. CCs will ensure members attend, coordinate transportation assistance, and follow up after missed appointments. Staff will utilize care reminders, provide or arrange transportation assistance through natural supports and available transportation resources and help the member prepare for visits. CCs will also follow up after missed appointments to address barriers, reschedule, and support the Enrollee's attendance. These activities - linking members to needed resources, scheduling appointments and facilitating follow up - are continuous functions of BHCP staff. Additional specific strategies are in 7.3.C.3.

Ensuring person's stability and satisfaction following a transition in care

In the course of the ongoing provision of CP supports, and in order to ensure a member's stability and satisfaction following a transition, staff will ask enrollees about their stability and satisfaction following a transition. With consent, CCs will follow up with family, significant others, providers and other CT members to get their assessment about the Enrollee's transition. CCs will ensure Enrollees and their support systems know how to reach the BHCP and other supports including the ESP/MCI if the Enrollee or others around them have concerns about their stability following a transition in care.

Preventing and managing other types of transitions in care

BHCP providers have robust experience with preventing transitions in care, e.g., supporting Enrollees to maintain community tenure and avoid unnecessary ED utilization and admissions to higher levels of care. This expertise is derived from many programs including Advocates/Wayside strong track record as an ESP/MCI provider, Advocates Emergency Department Diversion and Wraparound Team, Advocates CBFS, Wayside's CSAs and many other programs. BHCP staff will be trained on strategies to prevent unnecessary transitions in care, as well as facilitating transitions to lower levels of care other than hospitalizations when possible.

5. Medication Reconciliation

BHCP will conduct medication reconciliation, performed by the RN on the CP Team, for Engaged Enrollees discharged from inpatient stays. The complexity and intensity of these activities will increase based on the Enrollee's number of medications and prescribers. BHCP's care management software will be helpful in documenting these activities and may automate some components of the medication reconciliation process. Also, the RN may be able to work with pharmacies in carrying out some of these roles. Genoa Pharmacy, co-located with one of Advocates outpatient clinics, verifies medication orders with PCPs, verifies medications across all prescribers and asks people if they understand how to take their medications.

Verify medication orders are appropriate and filled accurately and Enrollee understands

With member consent, the RN on the CP team will communicate discharge medication orders to Enrollee's PCP or PCP designee. This would likely be a nurse to nurse conversation. The RN will ask for approval or notification if the PCP has concerns about the appropriateness of the orders.

Upon discharge, the CC will work with the Enrollee to ensure that medications are filled. The RN will verify that medication orders are filled accurately by looking at them and the prescriptions and comparing the orders and labels; review the instructions on the prescriptions and the inserts with the member; plan with the Enrollee how they will organize their medications and when they will take them. The RNs will involve CCs in this process so they are positioned to monitor medication administration going forward. The RN will identify any need for pill cassettes, prepackaged medications, or medication dispensing system and the CC will arrange for them.

Check for discrepancies and non-compliance, support adherence, identify supports, MAP

The CC, with support from the RN, will monitor the Enrollee's medication administration during visits and phone calls and assist them with any questions or barriers that arise. CC's will ask to view their medications and medication systems during visits and continually review how their system is working and if they need other systems or tools. CC's will consult with the supervising CCM and RN if they identify that a member may not be taking a medication, and the team will communicate with the prescriber, if consent is in place. If an Enrollee complains about side effects, CC's will consult with CCM and RN and facilitate follow up with prescriber. If an Enrollee disagrees with the medication orders, CCs will use shared decision making skills to engage the person in addressing this with the prescriber, as noted in 7.3.C.3. Staff will be trained to support Enrollees in medication administration. For BHCP Enrollees participating in a Medication Assistance Program (MAP), the RN will oversee the sharing of updated medication order forms from Enrollee's PCP or discharging prescriber with the MAP providers.

6. Health and Wellness Coaching

BHCP will conduct all required health and wellness coaching (HWC) activities as indicated in the Engaged Enrollee's person-centered treatment plan. As detailed in 7.2.D.2., the CEs and AP have robust health and wellness programs. They will use their experience with a wide range of HWC programs and approaches. Enrollee specific HWC activities will be provided or coordinated by the CCs and programs for groups of Enrollees will be provided across the CP utilizing RNs, CCMs and CCs. CCs will be trained in community health worker competencies and these programs will be supported by HWC staff and resources in the CEs and AP agencies.

a. Health and wellness education, coaching and health promotion programs

BHCP will directly provide and link to home and community based resources to help people manage health conditions. BHCP staff will conduct education about wellness issues including nutrition, weight management, exercise, stress management and smoking; help members link to health plans' health and wellness and disease management programs such as those for asthma and diabetes; and facilitate their use of available community based programs including gyms with which CEs and AP have negotiated reduced or no-cost arrangements, farmers markets such as a mobile market that Edward M Kennedy Community Health Center is starting, and the many programs that local hospitals offer including disease-specific education programs. BHCP staff will also make use of the wide array of health and wellness programs within the CEs and AP, some of which are listed in 7.2.D.2. Some of these health and wellness activities relate to assessing support relative to social needs that affect health such as nutrition. SMOC brings extensive resources to the BHPMW BHCP in these areas.

Health education, coaching, and symptom management activities will be geared toward enabling Enrollees to be knowledgeable in the prevention and management of chronic medical conditions including asthma, diabetes, heart health and metabolic conditions. Other activities will focus on educating enrollees on how to reduce high risk behaviors and health risk factors, e.g., smoking, inadequate nutrition or infrequent exercise. These activities will take shape in classes, groups and events offered to various focus populations across the proposed Service Areas. BHCP will utilize data on Enrollees' medical conditions and social needs that affect health as well as health and wellness goals in their treatment plans to target health and wellness activities for BHCP Enrollees across the Service Areas. The numerous CE and AP locations therein will be used to host these health and wellness activities.

b. Ensuring goals for the health and wellness programs are recorded and tracked

BHCP comprehensive assessment tool found in the attachments for this section contains several questions about health and wellness domains and assesses the member's interest in addressing them. CCs will use this to assist Enrollees in setting health and wellness goals in the person-centered treatment plan. Members' priorities tend to be basic needs such as housing and they may need to be encouraged to identify goals related to health and wellness. CCs will raise these areas proactively. These goals will be entered in the treatment plan in the care management system. Enrollee attendance at HWC activities will be documented and progress tracked in the treatment plan update process. Many of these applications address various health and wellness domains and contain tracking of Enrollees' goals and progress.

7. Connection to Community and Social Services

BHCP will connect Engaged Enrollees to social services and community resources and ensure ongoing connections. The CEs and AP are extensively embedded in their communities and connected to social services and community resources, as documented in 7.2.D.3.e. and 7.3.B.

SMOC brings longstanding expertise and comprehensive resources to the BHPMW BHCP from decades of providing services and supports that address social needs that affect health to the focus populations. These resources include the following: housing services, homelessness housing continuum, rental assistance, tenancy education, financial assistance, fuel assistance, employment services, education services, workforce development, green jobs academy, English as Second Language, nutrition, domestic violence programs, young parents program, Head Start, and child care. SMOC offers these services in many of the proposed Service Areas, with hubs in Framingham, Lowell and Worcester, so these community-based social services will be accessible to BHPMW BHCP Engaged Enrollees across the geography.

How Engaged Enrollees will be connected to social services and community resources

The process will begin with identifying Engaged Enrollees' social service needs through specific questions in the BHCP comprehensive assessment tool located in the attachments for 7.3.C.2. BHCP may use additional tools to assess for community-based, social and Flexible Services needs employing additional tools that SMOC utilizes. Once such tool assesses ten domains including homelessness, health care, independent living skills, and survival skills, rating each area on a four point scale: vulnerable, safe, building capacity, empowered. Based on the BHCP comprehensive assessment and any specialty assessment tools used, Care Coordinators (CC) and Engaged Enrollees will identify needs, goals, services and supports in the person-centered treatment plan.

CCs will follow procedures to link Engaged Enrollees to these resources - similarly to how they will connect them to medical, BH and other services as described in 7.3.C.3. and 7.3.C.4. They will inform members of social services resources and options; engage them in choosing the supports they need and want; arrange appointments or attendance at services and programs and/or apply for resources; coordinate transportation assistance if needed; help prepare for the first meeting or use of the resources; accompany the member to the appointment if needed; follow up to ensure participation; and assess member satisfaction.

Addressing some of the Engaged Enrollee's social needs that affect health may require funding. When this need arises, the CC will prepare a recommendation for Flexible Services to be submitted to the Engaged Enrollee's ACO, following the procedures established by the ACO for this purpose. All Flexible Services recommendations will be reviewed and approved by the Engaged Enrollees' Clinical Care Managers before submission to the ACOs. Tasks will be generated in the care management software to remind the CCs to follow up on these requests if responses are not received from the ACOs within the agreed upon timeframes.

CCs will facilitate ongoing linkages by monitoring the members' use of these resources and establishing and maintaining contact with the social service providers and community organizations. Enrollees will be encouraged to include these stakeholders in their Care Teams, particularly if it is expected that they will utilize their supports in an ongoing manner. CCs will follow procedures for ensuring ongoing connections to community resources and social services similar to strategies delineated in 7.3.C.3.

SMOC will train BHCP staff in all CEs and AP on assessing for community and social service needs; educate them on resources; and consult around accessing needed services. BHPMW BHCP will further support the CP teams by proving access to the database that has been created of the member agencies' services and supports. The BHPMW Director of Population Health and Quality Management will also assist by identifying available resource directories and compiling service information to fill gaps. BHCP's selected care management software, Care Navigator, contains tools for resource information in the system.

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Behavioral Health Partners METROWEST

Behavioral Health Community Partner Comprehensive Assessment Tool

Enrollee Information:

Name: _____ DOB: _____ Date: _____

Address: _____

Phone: _____ (type:) Phone: _____ (type:) Phone: _____ (type:)

Initial Assessment: ☐ **Annual Assessment:** ☐

1. Review of Referral: You were referred because: (staff shares referral info)

a. Do you agree? ☐ Y ☐ N Explain or add information as needed:

b. Are you your own guardian? ☐ Y ☐ N ☐ I Don't Know If no, do you have a guardian? ☐ Y ☐ N ☐ I Don't Know

If yes, guardian name and contact info:

c. Do you have immediate health care needs of any type? ☐ Y ☐ N ☐ I Don't Know Explain and add information:

d. Do you have other immediate concerns about your medical condition and wellbeing? ☐ Y ☐ N ☐ I Don't Know Explain and add information:

2. Tell me about your strengths, needs, and goals:

a. Describe your Strengths:
Challenges: Needs:
b. What are your personal goals?
c. What are your overall health goals?
d. How do you manage stress?

3. Tell me about your interests and leisure activities:

a. What are your interests, hobbies and pastimes?
b. What do you do for socialization and enjoyment?
c. Are you involved in volunteer activities? ☐ Y ☐ N
d. Do you participate in a faith community or spiritual activities? ☐ Y ☐ N
e. Do you participate in a cultural community or cultural activities? ☐ Y ☐ N
f. How else are you involved in your community?
g. How can we assist you in this?

4. Describe your social supports, social network and peer support relationships:

a. Do you currently have supports? ☐ Y ☐ N ☐ I Don't Know b. If yes, describe:
c. If no, what are your hopes, needs, and potential resources?
d. How can we assist you in this?

5. Functional Status: Do you need assistance with any of the following Activities of Daily Living? ☐ Y ☐ N ☐ I Don't Know

☐ Personal Care Skills (includes groom and dress) ☐ Housekeeping/Laundry
☐ Transportation ☐ Grocery Shopping/Food Prep. ☐ Time Management
☐ Safety/Self Preservation ☐ Problem Solving Skills ☐ Money Management
☐ Other: _____

a. If yes, please describe:
b. How can we assist you in this?
c. Is staff observation consistent with client report? (Make note of enrollee's presentation) d. Other info:

6. Do you have any accessibility requirements: ☐ Y ☐ N ☐ I Don't Know

If yes, which of the following?

☐ Language ☐Communication ☐Transportation ☐Equipment
☐ Other: _____ If yes, how can we assist you in this?

7. According to the referral we received, your medical history includes: (staff shares referral info)

a. Is that correct? ☐ Y ☐ N ☐ I Don't Know Explain and add information: b. Your family history includes:

Is that correct? ☐ Y ☐ N ☐ I Don't Know Explain and add information: c.
Your medications are:
Is that correct? ☐ Y ☐ N ☐ I Don't Know Explain and add information:
d. Do you have physical limitations or mobility issues? ☐ Y ☐ N ☐ I Don't Know
Explain and add information

8. According to the referral, your current and past mental health history is: (staff shares referral info regarding diagnoses, treatment history, etc.)

a. Is that correct? ☐ Y ☐ N ☐ I Don't Know Explain and add information:

9. According to the referral, your current and past substance use and history is: (staff shares referral info regarding use, diagnoses, treatment history, etc.)

a. Is that correct? ☐ Y ☐ N ☐ I Don't Know Explain

10. Do you have a history of trauma? ☐ Y ☐N ☐ I Don't Know

a. If yes, which of the following have your experienced?
☐ Physical neglect ☐Emotional neglect ☐Exploitation ☐Physical abuse
☐ Witness to violence ☐Domestic abuse ☐Elder abuse ☐Other: _____
b. Explain and add information about history and/or trauma intervention:

11. Review of current services, including but not limited to medical, behavioral health, care coordination or care management and services provided by state agencies, (Prompts: medical, therapy, psych, PCP, DMH, CBFS, PACT, DPH, DCF, DYS, DDS, MRC, MCB, MCDHH, primary care, specialty medical care, dental, skilled nursing, visiting nurse, home care, home health aides, PCA, Other). Is there anyone else that helps you in your home or through any other services and supports?

a. Provider Contact Information: (list all)

NAME	AGENCY	ROLE/SERVICE	PHONE	ADDRESS	EMAIL

b. Are these providers and services meeting your needs? ☐ Y ☐ N ☐ I Don't know
Explain what needs are not being met.
How can we better meet them?
What other services and supports do you want and feel you need?

12. Education:

a. According to the referral, the highest educational level you have achieved is: Is that correct? ☐ Y ☐ N ☐ I Don't Know
   Explain and add information:
b. Are you currently enrolled in an educational program? ☐ Y ☐ N If yes, please explain.
c. Do you have interest in further education? ☐ Y ☐ N ☐ I Don't Know If yes, what are your goals and how can we assist you in this?

13. Employment:

a. According to the referral, your employment history is: Is that correct? ☐ Y ☐ N ☐ I Don't Know

   Explain and add information:

b. Are you currently employed? ☐ Y ☐ N ☐ I Don't Know
   If yes: What is your position?
   Length of employment:
   Weekly hours worked:
   Income:
   Do you like your job?
c. Do you have other employment goals?
d. Do you have interest in training and/or other assistance related to employment?

14. Income/Financial Support: (In addition to any information under 'employment')

a. What is your source of income?
b. What is the total amount monthly?
c. Do you receive any sources of financial assistance:
   ☐ SNAP ☐ Fuel Assistance ☐ EAEDC ☐ Food stamps ☐ Disability
   ☐ TAFDC ☐ Veteran's benefits
d. Are you able to meet all of your monthly bills? ☐ Y ☐ N If no, describe?
e. How can we assist you in this?

15. Housing – Where do you live?

☐ Own Room ☐ Own apartment ☐ Own home (roommates:)

☐ Shelter ☐ Homeless/street ☐ Temporary with family/friend

☐ Residential program or group home ☐ Other: _____

a. Does your current housing meet your immediate needs? ☐ Y ☐ N
b. Do you have housing related needs? ☐ Y ☐ N Explain:

16. Do you have access to enough food? ☐ Y ☐ N

a. What is your primary source?
   ☐ Grocery store ☐ Convenience store ☐ Fast food ☐ Food pantry ☐ Other: _____

b. Do you have a diet restriction or special diet? ☐ Y ☐ N ☐ I Don't Know
c. Are you able to follow your diet? ☐ Y ☐N ☐ I Don't Know
d. If no, what are the obstacles?
e. How can we assist you in this?

17. Do you exercise? ☐ Y ☐ N

a. How frequently?
b. What type?
c. Would you like to exercise more? ☐ Y ☐ N ☐ I Don't Know
d. What type?
e. Are you concerned about your weight? ☐ Y ☐ N ☐ I Don't Know
f. How can we support you in this?

18. Do you have current and/or past legal issues? ☐ Y ☐ N ☐ I Don't Know

a. Describe any current and/or past legal experiences/arrests/convictions:
b. Are you on parole/probation? ☐ Y ☐ N ☐ I Don't Know
c. Name of PO:
d. How can we assist you in this?

19. Do you ever feel threatened or unsafe at home and/or in your community? ☐ Y ☐N ☐ I Don't Know

a. In what way?
b. Where?
c. By Whom?
d. Do you have a safety plan in place? ☐ Y ☐ N ☐ I Don't Know
If yes, locate and review with Enrollee.
If no, would you like to develop one? ☐ Y ☐ N ☐ I Don't Know

20. According to the referral, you ☐HAVE ☐DON'T HAVE a current acute care plan.

If yes, locate it and review with Enrollee.

a. If your condition becomes acute, what needs to happen?
b. What does and does not help?
c. What is your preferred facility(s)?
d. Who will take care of your children, animals, plants, etc.?
e. Who do you want to be notified?
f. Do you have other immediate needs? ☐ Y ☐ N ☐ I Don't Know Explain and add information:

21. According to the referral, it says you ☐DO ☐DO NOT have an Advanced Medical Directive:

a. Is that correct? ☐ Y ☐ N ☐ I Don't Know
b. Do you want one? ☐ Y ☐ N ☐ I Don't Know
c. Do you want more information about it? ☐ Y ☐ N ☐ I Don't Know

d. Do you have a health care proxy? ☐ Y ☐ N ☐ I Don't Know If yes, name and contact info:

22. Do you have a plan for preventing and managing mental health or substance use crises? ☐ Y ☐ N ☐ I Don't Know

a. If yes, do you have a copy? Do you know who does? (Prompts: ESP, CBFS staff, group home staff, other). Locate and review with Enrollee.
b. If no, are you interested in developing one? ☐ Y ☐ N ☐ I Don't Know

23. Is there anything else you want to tell me or discuss? If yes, describe:

Enrollee approval:

Enrollee Name (print)	Enrollee Signature	Date

Care Coordinator completing assessment:

CC Name (print)	CC Signature	Date

***RN review of medical history, medical needs, and medications:**

RN name & credentials (print)	RN Signature	Date

***Clinical Care Manager Final Review and Approval:**

CCM name & credentials (print)	CCM Signature	Date

*Any feedback, concerns, or recommendations will be discussed with CC and the assessment adjusted as needed before signing.

D. Innovative Technologies for Service Delivery

BHPMW BHCP will use current and new innovative technological tools for the delivery of CP supports. Staff will be provided with laptop computers and smart phones. CEs and AP use adaptive communications technology including video phones and a language line and will do so in providing BHCP services. In some of these agencies' care management and other programs, staff are accustomed to using automatic pill dispensers and electronic medication reminder systems. All CEs and AP use e-prescribing and work with pharmacies in different ways. Advocates on-site pharmacy, Genoa, offers unique capabilities including pre-packing multiple medications in the same slot in a bubble pack, which increases adherence; visuals to verify medications; personalized refill processes; and mailing medications. This pharmacy can be used for any of the BHCP Engaged Enrollees regardless of which CE or AP provides CP supports to them.

Care management software

As described in 7.2.E., the care management software that the BHPMW plans to purchase, Blueprint Technology's Care Navigator, will be the major new technology that will be used in the delivery of CP supports. The system is not simply a depository for documentation; it is a tool that facilitates care coordination workflows; generates reminders, calendars and alert dashboards; and organizes care coordination teams and tasks. Care Navigator's functionality offers technology solutions for many CP support tasks and BHCP Model Contract requirements, a sample of which includes: electronically assigning care coordinators; generating care reminders to alert them to Enrollee appointments; aggregating medication information from external sources such as discharge documents; sending completed comprehensive assessments to Clinical Care Managers for review; facilitating communication and coordination among internal and external Care Team members through multiple mechanisms; tracking and reporting of disengagement reasons; and esignatures to obtain PCP approval of care plans and Enrollee signatures on participation forms. Care Navigator is committed to building additional features to facilitate the delivery of CP supports and compliance with BHCP requirements.

Currently, SMOC uses Triggr Health, a mobile platform that uses behavior on and around the phone to predict the state of a person's recovery in real-time. It increases adherence to long-term continuing care, reduces relapse rates post-treatment and dramatically improves outcomes for those in early recovery. By analyzing phone data, Triggr Health predicts with 88-92% accuracy three days before a person relapses, enabling proactive outreach. The application includes motivation, support, goal setting and progress tracking.

The combined use of multiple technologies - care management software, information exchange through the MA HIway, , and various communications modes - will result in improved communication, coordination and integration among Enrollees, their Care Teams, BHCPs, ACOs, MCOs and EOHHS and its agencies.

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E. Personnel and Staffing

1. Program Organizational Chart

Please find the program organizational chart in the attachments for this section.

2. Sample Staffing Model

Table 15: BHPMW Program Staffing Model for Budget Year 1			
Position FTE	**Schedule**	**Reports to**	**Supervises**
Executive Director* .5 FTE	4 hours per day and as needed	Governing Board	Medical Director, BHCP Program Director
Medical Director* .05FTE	2 hours per week	Executive Director	- - - - - - - - - -
BH CP Program Director 1 FTE	8 hours daily Monday-Friday	Executive Director	Director of Population Health, Triage/Resource Coordinator, Chief Financial Officer, Billing Manager, Director of Information Technology, Consumer Advisory Board, Quality Management Committee
Chief Financial Officer* .1 FTE	4 hours per week and as needed	BH CP Program Director	.4 financial management staff
Director of Information Technology* .5 FTE	4 hours daily and as needed	BH CP Program Director	IT Services Staff
IT Services Staff** 1 FTE	8 hours daily Monday-Friday		also IT Configuration Staff 1 FTE
Billing Manager** 1 FTE	8 hours daily Monday-Friday	BH CP Program Director	- - - - - - - - - -
Administrative Assistant** .5 FTE	4 hours daily Monday-Friday	BH CP Program Director	- - - - - - - - - -
Director of Population Health Management .5 FTE	4 hours daily Monday-Friday	BH CP Program Director	Data Analyst, Designated Compliance Officer, BHCP Managers
Data Analyst** 1 FTE	8 hours daily Monday-Friday	Director of Population Health/QM	- - - - - - - - - -
Designated Compliance Officer* .2 FTE	8hours per week	Director of Population Health/QM	- - - - - - - - - -
Peer Specialist .2 FTE	8 hours per week	Director of Population Health/QM	To assist with development of the Consumer Advisory Council in year 1

Table 16: BHPMW Community Partner Care Management Teams Staffing Model			
Community Partner Care Management Teams - a total of 12-14 teams across 5 provider agencies; 9-10 teams in the Central Region and up to 4 teams in the North Region. Each team supports 275 members (non-CBFS) or 200 (CBFS).			
Position FTE per team	**Schedule**	**Reports to**	**Supervises**

BHCP Program Manager .2 FTE (note: Each CE and AP will start with .3 FTE for BHCP start date and FTE will increase based on this ratio as their Enrollee volume and teams grow.)	8 hours per week per team Monday-Friday	CE and AP Senior Operations Staff, secondary report to Director of Population Health/QM	Quality Manager, Registered Nurse, Peer Specialist/Recovery Coach/Family Partner, Clinical Care Manager, Administrative Assistant
Quality Manager .1 FTE	2 hours per week per team Monday-Friday	BH - CP Program Manager	- - - - - - - - - -
Registered Nurse Clinical Care Manager 1 FTE	8 hours per week per team Monday-Friday	BH - CP Program Manager	- - - - - - - - - -
Administrative Assistant .2 FTE	8 hours per week per team Monday-Friday	BH - CP Program Manager	- - - - - - - - - -
LMHP Clinical Care Manager .4 FTE	3.2 hours per day per team Monday-Friday	BH - CP Program Manager	Care Coordinator
Care Coordinator 5 FTEs	40 hours per day per team Monday-Friday	Clinical Care Manager	Some will be persons with lived experience .
Peer Specialist 1 FTE (note: This FTE is static, e.g., does not vary by # teams)	40 hours per day per team Monday-Friday	Clinical Care Manager	

* Stated FTEs for these positions are when the program is fully operational.

** These positions will start part-time and increase to full-time as the program ramps up to full capacity

3. Recruitment and Job Descriptions

BHPMW will implement multipronged strategies to ensure recruitment and retention of excellent employees at all levels. BHPMW will subcontract to one of the CEs, Advocates, who will use two full time recruiters to coordinate recruitment activities for BHPMW BHCP staff and for Advocates staff who will provide CP supports. The other CEs and AP will use their Human Resources departments and protocols to hire staff they will employ to deliver CP supports. Activities will include online recruitment through BHPMW partner agencies' websites and engaging candidates through social and networking sites such as LinkedIn, Facebook and Google+. Supervisors will be trained in effective interviewing techniques and consistent hiring practices to support the engagement of qualified candidates throughout the hiring process. Open positions will be posted to online job boards: Indeed, Jobs with Heart, area graduate school job boards, applicable professional membership groups, and NASW job link. Job postings will be shared on internal communications and newsletters as "job of the week" and highlighted as part of each agency's employee referral bonus program. The recruiters will reach out to personal and professional connections through current employees, such as Nurses and Case Managers in Adult Family Care with cultural and linguistic competence in serving Mandarin, Cantonese, Vietnamese, and Spanish speaking populations; and bilingual Clinicians in Outpatient and Emergency services with experience serving individuals in Latino and Brazilian communities.

Many employees across the five partner agencies have academic affiliations, e.g., teach or are field advisors, and those relationships will be tapped for potential candidates. Internship programs are also a source of excellent candidates. Open positions will be featured in on-site job fairs so candidates can speak directly with hiring managers.
Recruitment will begin upon notice of contract award, before the actual contract starts. Several key leadership positions are already in place using leased or in-kind staff from BPHMW CEs and AP. Remaining positions will be advertised immediately upon award. The Program Director will be the first employee hired. Recruitment staff will screen candidates to match them to other job vacancies; the Executive Director and/or Program Director will interview. Recruitment staff will ensure all necessary reference checks are completed prior to extending offers, and all background checks/CORI will be completed in compliance with Massachusetts law. BHCP will work toward filling all positions in time for staff training to occur before the contract start date.

Job descriptions for each position are attached.

4. Cultural and Linguistic Recruitment

The recruiters with whom BHPMW will work understand the inherent challenges in hiring bilingual or multilingual staff. They have developed effective recruiting strategies that have resulted in Advocates hiring: eight therapists who are fluent in Spanish and two therapists who speak Portuguese in outpatient services; staff who speak nine languages in Adult Family Care; staff who speak Mandarin, Cantonese, and Vietnamese in Family Support Centers and residential programs; and Deaf and hearing staff who are fluent in American Sign Language (ASL). They have found the most effective recruiting strategies to include advertising in local native language newspapers, reaching out to networks of professionals, and most importantly, working with existing multi-lingual and multi-cultural staff to identify potential employees. The recruiters have found that the most effective recruiting strategy is recruitment from current employees. These strategies – along with the usual linkages with on-line advertising, networking with local schools and colleges and traditional print advertising – will be used to recruit from diverse communities.

In addition to the recruitment strategies described above in section 7.3.E.3, specific strategies for the recruitment of staff from cultural and linguistic communities will include: employee referral; internal employee transfers and promotions; tapping relationships with area colleges and universities including career center staff as well as professors; attending school career fairs and information sessions; and connecting with professional membership groups such as National Association of Black Social Workers (NABSW), National Association of Puerto Rican Hispanic Social Workers (NAPRHSW), National Council for Behavioral Health, Latino Social Workers Organization (LSWO), and MA Mental Health Counselor Association (MaMHCA).

5. Staff Orientation and Training

All staff will be oriented to the BHCP model, BHPMW BHCP program, and all related policies, procedures and protocols. They will also be trained on the use of evidence-based practices (EBPs), which requires rigorous training. The systems-contextual (SC) training model for dissemination and implementation efforts underscores the importance of the provider, client, and organizational variables that influence training and consequent provider uptake and adoption of EBPs. Change in community provider behaviors (e.g., adherence, competence and skills) and client outcomes only occurs when interactive and experiential training addresses each level of the SC model and includes active learning (Sanders & Turner, 2005; Turner & Sanders, 2006). BHPMW's framework for orientation and training is based on the SC training model and the current "gold standard" of training in EBPs which includes the initial orientation based on a workshop modality with manuals, experientials and participant documentation, as well as

ongoing clinical training and supervision (Sholomskas, Syracuse-Siewert, Rounsaville, Ball, & Nuro, 2005).

The Initial Orientation Training as well as Annual Refresher Training modules are evidence-based and will be staff-integrated (nursing, clinical care managers, care coordinators, others) to promote thorough cohesion and engagement of provider staff, and participation will be documented for compliance tracking. Through this structured, interactive orientation and training plan, BHPMW will promote an atmosphere of service delivery and outcomes excellence.

Initial Orientation and Training Agenda

BHPMW will hold the CP contract with EOHHS and each CE and AP will employ staff (RN, Clinical Care Mangers, Care Coordinators, Peer Specialists, and others) to provide CP supports. BHCP staff will attend initial orientation at their respective agency employer. Staff across the BHPMW BHCP will then be brought together at a central location for a full day orientation to the BHCP program, the delivery of CP supports, and the EBPs they will be using. Additional training sessions will be conducted before the contract start date. Orientation and training topics include:

Program Overview: BHCP model; BHPMW BHCP structure and the roles and services offered by each CE and AP; and BHCP policies, procedures, protocols and plans including protocols for delivering each CP support and activity

Person-Centered Treatment Planning Module, based on EOHHS standards; ATTC Network: engaging in collaborative conversations directed by clients in partnership with care providers and natural supports; fostering a recovery orientation in care planning discussion; and treatment planning endorsed by members which addresses their needs and preferences

Cultural Competency Module, based on the American Counseling Association and CLAS Standards: awareness of own cultural values and biases; limits of own competencies and expertise; comfort level with differences; knowledge about own racial and cultural heritage and its effects on others; and knowledge about own social impact on others

Accessibility and Accommodations Module, based on EOHHS standards: written information availability and oral interpretation services accessibility in prevalent non-English languages; alternate format information availability and accessibility for special needs; and Enrollee coordination and accommodation of visits with Care Coordinators

Independent Living and Recovery Principles Module, based on SAMHSA National Council on Independent Living: peer support; information and referral; individual and systems advocacy; independent living skills training; transition; and BH/Recovery Support Navigators

MassHealth State Plan LTSS and Eligibility Criteria Module, based on EOHHS standards: eligibility criteria; co-occurring and LTSS needs; managing and coordinating care; and supporting transitions in care

HeClth and Wellness Principles Module, based on SAMHSA's Eight Dimensions of Wellness: emotional - coping effectively with life and creating satisfying relationships; environmental - good health by occupying pleasant, stimulating environments that support well-being; financial - satisfaction with current and future financial situations; intellectual - recognizing creative abilities and expanding knowledge and skills; occupational - personal satisfaction and enrichment from one's work; physical - recognizing the need for physical activity, healthy foods, and sleep; social - developing a sense of connection, belonging, and a well-developed support system; and spiritual- expanding a sense of purpose and meaning in life

Motivational Interviewing Module, based on Rollnick and Miller: express and show empathy; support and develop discrepancy; deal with resistance; support self-efficacy; and autonomy

Trauma-Informed Care Module, based on SAMHSA TIP 57: safety; trustworthiness and transparency; peer support and mutual self-help; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues

Conflicts of Interest and Mitigation Module: conflicts of interest defined; personal conflicts of interest/organizational conflicts of interest implications; identifying potential conflicts; overview of organizational conflict of interest mitigation plans.

Each CP staff person will attend an annual refresher training that will review the training modules from the Initial Orientation Training; other select training topics will be presented in more depth on an annual basis. One additional training priority will be Community Health Worker competencies. The Spectrum Vice President of Clinical Development will take the lead in developing training modules to prepare Care Coordinators and other staff in these skill areas. Training on common medical conditions will be included. Training will also be provided on additional EBPs: wraparound, peer support and shared decision making. Program outcome measures will be used to identify areas that need improvement and training will be tailored to address those areas. Per policy, staff will be required to complete a post-test to indicate understanding of the topic presented. Staff identified as needing more training in a specific area will be directed to their supervisor to correct the deficiency.

6. Staff Retention Strategies

Retention of highly qualified knowledgeable staff is achieved through creating a work environment in which all staff are valued, staff are offered opportunities to learn and grow and a meaningful connection is made between the individual staff role and the mission and philosophy of the larger agency. It starts at the initial interview process by offering candidates insights on actual experiences and discussing all aspects of the job (known as a realistic job preview). Once hired, staff orientation at each provider agency is important in providing necessary trainings and certifications; opportunities to meet various leaders who conduct orientation sessions; and an accurate job description.

BHPMW and the CEs and AP will maintain an Open Door Policy, encouraging employees to feel comfortable speaking with anyone through all levels of the organization. A Problem Resolution Process will be in place to facilitate the communication of issues or concerns that arise through proper leadership channels; and to ensure issues are addressed in a timely and appropriate manner. As BHPMW operations are established, retention activities will be initiated such as team building opportunities, employee satisfaction surveys, longevity awards, peer nominated awards, and employee appreciation and recognition activities/events.

BHPMW will offer employees a comprehensive benefits package including medical, dental and vision insurances, tuition reimbursement and a 401(k) plan. BHPMW staff will be able to access services through Advocates Employee Assistance Program. A generous paid time off program will be offered that will increase with length of employment.

Professional development opportunities will be provided by each CE and AP. BH CP staff will be able to access required and professional development training sessions offered by partner agencies including agency sponsored CEU training opportunities.

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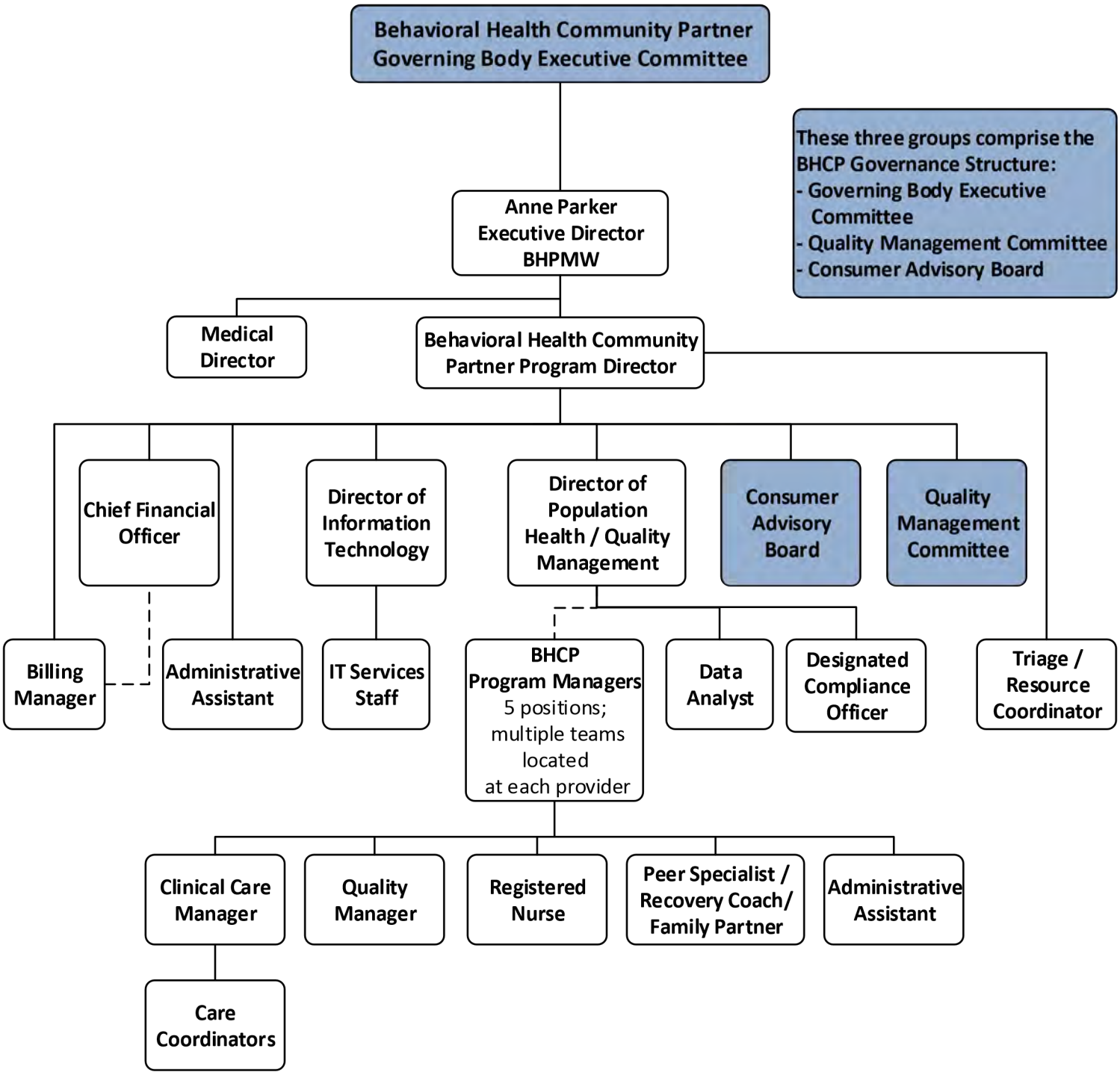
Section 7.3 Initial DSRIP Plan

Attachment 7.3E1

Behavioral Health Partners of MetroWest

BH CP Program Organizational Chart

May 2017



Behavioral Health Partners
METROWEST

BHPMW, LLC FUNCTIONAL JOB DESCRIPTION

Job Classification:	**Administrative Assistant**
Reports to:	**BH CP Program Director**
FLSA Status:	**Non-Exempt**

Job Summary:
The Administrative Assistant will provide overall administrative support to the BHPMW's BH CP program. The Administrative Assistant is responsible for maintaining efficient and accurate office procedures, providing clerical support to program staff, keeping meeting minutes, and maintaining administrative records. This position is also responsible for facilitating information exchange between the BHPMW BH CP and the Community Partner Teams at the consortium entities and affiliated partner agencies.

Essential Functions:

1. Perform word processing/typing for division staff to include letters, memos, and meeting minutes.
2. Perform data processing tasks for program record keeping.
3. Assist with the flow of Enrollee assignments, data and information between the BHPMW BH CP and the Community Partner Teams at the consortium entities and affiliated partner agencies.
4. Maintain office supplies for program.
5. Coordinate appointments and staff meetings; and coordinate professional meetings as needed. Serves as point of contact for meeting communications and for assuring the appropriate people participate.
6. Work in partnership with the program directors/managers and other staff on coordination of logistics for events.
7. Attend and actively participate in supervision and staff meetings.
8. Attend trainings as assigned; maintain necessary certifications.
9. Ensure that individuals are treated with dignity and respect in accordance with BHPMW Human Rights Policy.
10. Perform all duties in accordance with the agency's policies and procedures.

Please note: The essential functions listed in this section are not limited only to the tasks listed and may include other duties as assigned.

Qualification/Education/Experience:

1. High School Diploma or GED and 1-2 years administrative experience.
2. Must be able to perform each essential duty satisfactorily.
3. Ability to type 50+ words per minute.
4. Must have knowledge of Microsoft Office Suite.
5. Must have knowledge of office procedures and equipment.
6. Must have exceptional organizational skills and ability to multitask in busy environment.
7. Must have excellent communication skills and ability to read English.

Physical Demands:
The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

General requirements:

1. Full upper extremity range of motion
2. Full lower extremity range of motion

***Continuous:**	Communication
***Frequent:**	Standing, sitting, walking, and lifting
***Occasional:**	Reaching with hands and arms, stooping and crouching

RECEIPT AND REVIEW OF FUNCTIONAL JOB REQUIREMENTS

I, _____, have read, understand and agree to the above functional job description. I understand the essential functions, qualifications, education, experience, and physical demands of the position and acknowledge that I am capable of performing all of the essential functions of this position without reasonable accommodation or I have informed you of my need for an accommodation. I understand that the contents as presented are a matter of information and should in no way be construed as a contract between BHPMW LLC and its employees. BHPMW LLC reserves the right to change any part of this job description, as circumstances require.

Signature_____Date _____

Witness_____Date _____

Behavioral Health Partners
METROWEST

BHPMW, LLC FUNCTIONAL JOB DESCRIPTION

Job Classification:	**Behavioral Health Community Partner Program Manager**
Reports to:	**Director of Population Health / Quality Management**
Supervise:	**Clinical Care Managers**
FLSA Status:	**Exempt**

Job Summary:

The Behavioral Health Community Partner Program (BHCP) Manager develops and manages the daily operations of the Behavioral Health Community Partners care management service line on-site at respective BHPMW BHCP consortium entities (CE) and affiliated partner (AP) agencies. This position oversees all CP Teams and the provision of all CP supports within the assigned CE or AP.

Essential Functions:

1. Lead the development and management of the BH CP at respective agency; serve as agency liaison to the BHPMW for the BHCP program.
2. Develop multi- disciplinary staffing pattern, within the BH CP at respective agency to provide BH CP services.
3. Hire, train, supervise, and evaluate clinical care managers, RNs and Quality Manager. Maintain consistent communication with staff and conduct regularly scheduled staff meetings. Provide and document clinical supervision to service line staff. Provide back up to service line staff as needed during emergencies or staff vacancies.
4. Oversee the receipt of Assigned Enrollees from the BHPMW BHCP and assign them to Care Teams.
5. Provide direct services within the care management services lines, including assessment and care plan development, as needed and appropriate.
6. Ensure that care management services are delivered in accordance with BHPMW clinical philosophy. Create and maintain a welcoming, recovery oriented, trauma informed, culturally sensitive environment and treatment approach. Ensure that clients are treated with dignity and respect in accordance with BHPMW's Human Rights Policy.
7. Collaborate with the BHPMW Director of Population Health / Quality Management and Compliance Officer in ensuring that the provision of care management services complies with BHPMW BHCP policies, procedures and quality standards as well as licensing, regulatory, and payer requirements.
8. Collaborate with other BHPMW providers and community resources to provide and obtain consultation, and access services needed by persons served in the care management program.
9. Collaborate with the BHPMW Director of Population Health / Quality Management to identify and measure care management outcomes, consistent with the needs of persons served and the goals of payers.
10. Working with the BHPMW Program Director and Director of Population Health / Quality Management, ensure management of BHCP service delivery including meeting contractual requirements and billing and outcomes data is reported as required.
11. Identify community providers and related agencies to be developed as community resources, to meet the needs of persons served in the care management program.
12. Perform all duties in accordance with the agency's policies, procedures and standards.

Please note: The essential functions listed in this section are not limited only to the tasks listed and may include other duties as assigned.

Qualification/Education/Experience:

1. MA/MS/MSW degree in social work, behavioral health, human services, healthcare or a related field, or RN with experience in one of these fields
2. Massachusetts clinical license required, independent practice licensure preferred.
3. Minimum of five years of clinical experience, two years of intake and/or care coordination experience required. Two years of supervisory and management experience preferred. Any of these experiences may overlap.
4. Demonstrated knowledge base and judgment necessary for independent clinical decision making. 5. Training in care coordination and integration of medical and behavioral health services preferred.
6. Experience developing and managing internal and external relationships.
7. Strongly prefer that a candidate will have a demonstrated understanding of and competence in serving culturally diverse populations.
8. Ability to read and write English and communicate effectively in the primary language of the program to which he/she is assigned.
9. High energy level, flexibility, superior interpersonal skills, and ability to function in a multidisciplinary team atmosphere while also working independently.
10. Strong skills in the areas of organization, follow through, collaboration, customer service, problem solving, and negotiation.
11. Commitment to BHPMW and partner agencies' values, missions, and goals.
12. Computer skills, including Word, Excel and Outlook, ability to learn new systems, and experience working with data
13. Valid driver's license and access to insured auto.
14. Ability to perform each essential duty satisfactorily.

Physical Demands:

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

General requirements:

1. Full upper extremity range of motion
2. Full lower extremity range of motion

***Continuous:** Hearing, talking

***Frequent:** Standing, sitting, walking

RECEIPT AND REVIEW OF FUNCTIONAL JOB REQUIREMENTS

I, _____, have read, understand and agree to the above functional job description. I understand the essential functions, qualifications, education, experience, and physical demands of the position and acknowledge that I am capable of performing all of the essential functions of this position without reasonable accommodation or I have informed you of my need for an accommodation. I understand that the contents as presented are a matter of information and should in no way be construed as a contract between BHPMW, LLC and its employees. BHPMW, LLC reserves the right to change any part of this job description, as circumstances require.

_____ _____

Signature Date

_____

Witness

Behavioral Health Partners
METROWEST

BHPMW, LLC FUNCTIONAL JOB DESCRIPTION

Job Classification:	**Billing Manager**
Reports to:	**Behavioral Health Community Partner Program Director with dual report to the consortium entity that is subcontracted to perform billing across the BHCP program**
FLSA Status:	**Exempt**

Job Summary:

The Billing Manager is responsible for producing and submitting claims for all BHCP supports and activites, conducted by the BHCP consortium entities (CE) and affiliated partner (AP) staff, to MassHealth.

Essential Functions:

1. Oversees and implements billing of BHCP supports and activities to MassHealth.
2. Oversees the maintenance of billing data files.
3. Attends all meetings pertaining to MassHealth billing of BHCP supports and activities.
4. Attendance at supervision and staff meetings.
5. In collaboration with BHCP leadership, interfaces with external vendors and other stakeholders related to billing..
6. Coordinates with the CFO and appropriate staff to change and implement billing operation policies and procedures.
7. Interacts with IT Services staff on computer based reporting systems as needed.
8. Develops and updates billing manual.
9. Performs all other duties and assignments as directed by the Behavioral Health Community Partner Program Director.
10. Ensure that clients are treated with dignity and respect in accordance with BHPMW's Human Rights Policy.
11. Perform all duties in accordance with the agency's policies and procedures.

Pls note: The essential functions listed in this section are not limited only to the tasks listed and may include other duties as assigned.

Qualification/Education/Experience/Personal Characteristics:

1. BS/BA in Accounting preferred.
2. Three years' experience in third party billing with Medicaid, Medicare and/or commercial insurance.
3. Working knowledge of billing systems and ability to operate personal computers.
4. Must be able to perform each essential duty satisfactorily.
5. High energy level, superior interpersonal skills and ability to function in a team atmosphere.
6. Must have valid driver's license and access to auto.
7. Must have excellent communication skills both verbal and written.

9. Ability to read and speak English.

Physical Demands:

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

General requirements:

1. Full upper extremity range of motion
2. Full lower extremity range of motion

***Continuous:**	Hearing, talking
***Frequent:**	Standing, sitting, walking

RECEIPT AND REVIEW OF FUNCTIONAL JOB REQUIREMENTS

I, _____, have read, understand and agree to the above functional job description. I understand the essential functions, qualifications, education, experience, and physical demands of the position and acknowledge that I am capable of performing all of the essential functions of this position without reasonable accommodation or I have informed you of my need for an accommodation. I understand that the contents as presented are a matter of information and should in no way be construed as a contract between BHPMW, LLC and its employees. BHPMW, LLC reserves the right to change any part of this job description, as circumstances require.

Signature _____ Date _____

Witness _____ Date _____

Behavioral Health Partners
METROWEST

BHPMW, LLC FUNCTIONAL JOB DESCRIPTION

Job Classification:	**Care Coordinator**
Reports to:	**Clinical Care Manager**
FLSA Status:	**Exempt**

The Behavioral Health Community Partner (BHCP) Care Coordinator provides CP supports and activites to Assigned Enrollees.

Essential Functions:

1. Utilize effective, dignified, empowering and creative engagement strategies to ensure Enrollees are at the center and lead in their BHCP services.
2. Conduct outreach and engagement activities with Assigned Enrollees and engage them in enrolling in the BHCP program.
3. Complete comprehensive assessment in a collaborative manner with Engaged Enrollees, under the supervision of the Clinical Care Manager, and with input from Care Team members and other stakeholders. Conduct annual re-assessments.
4. Develop a person-centered treatment plan with each Engaged Enrollee, under the supervision of the Clinical Care Manager, and with input from Care Team members and other stakeholders. Update the treatment plan according to required timeframes.
5. Develop advanced directors, acute care plans, and/or crisis plans with Engaged Enrollees as needed.
6. Work with Engaged Enrollees to assemble Care Teams and facilitate all communication and coordination with the team.
7. Support Engaged Enrollees during care transitions including attendance at discharge planning meetings, face to face meetings post discharge, ensuring linkages with all needed services and supports, and facilitating Enrollee participation in those services.
8. Assist the RN with medication reconciliation functions as needed and requested, such as information collection.
9. Provide health and wellness coaching to Engaged Enrollees and assist them identifying and utilizing health and wellness supports in the community.
10. Connect Engaged Enrollees to all needed services and supports including those that address social needs that affect health. Facilitate ongoing connection.
11. Collaborate with existing providers, Care Team members, state agency staff, and all other stakeholders and delivers CP supports and activities in accordance with Enrollee's person centered treatment plan.
12. Participate in BHCP team meetings and each Engaged Enrollee's Care Team to ensure effective communication among all disciplines and stakeholders involved in the person's care.
13. Identify community resources and develop natural supports for client.
14. Participate in all required orientation and training.
15. Learn all BHCP policies, procedures, protocols and plans and deliver CP supports and activities in compliance with them.
16. Develop knowledge about all focus populations.
17. Learn evidence based practices identified by the BHCP and deliver CP supports and activities in compliance with them.
18. Complete all required documentation in a timely manner.

19. Attends and actively participates in supervision and staff meetings.
20. Consults with Clinical Care Managers, RNs and other CP Team members as needed around clinical, medical and other matters.
21. Provide on-call coverage, as needed.
22. Ensure that all clients are treated with dignity and respect in accordance with BHPMW's Human Rights policy.
23. Perform all duties in accordance with the agency's policies and procedures.
24. Strictly follow all agency Performance Standards.

Please note: The essential functions listed in this section are not limited only to the tasks listed and may include other duties as assigned.

Qualification/Education/Experience:

1. Minimum of 2 years experience working with adults in a community-based and/or medical setting; BA/BS degree in a related field preferred.
2. Demonstrated knowledge base and judgment necessary for independent decision making.
3. Excellent verbal and written communications skills. Strong interpersonal and customer relations skills required.
4. Excellent organizational, time management and problem solving skills.
5. Ability to openly address and acknowledge issues of substance use and mental illness.
6. Knowledge regarding psychiatric rehab and understanding of recovery model.
7. Must be able to perform each essential duty satisfactorily.
8. Strongly prefer that a candidate will have lived experience with mental health, substance use, and/or social needs that affect health.
9. Strongly prefer that a candidate will have a demonstrated understanding of and competence in serving culturally diverse populations.
10. Ability to develop and maintain satisfactory working relationships with employees and providers.
11. Must hold a valid drivers' license. Must have access to an operational and insured vehicle and be willing to use it to transport members.
12. Ability to read and speak English.

Physical Demands:

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

General requirements:

1. Full upper extremity range of motion
2. Full lower extremity range of motion

***Continuous:**	Communication
***Frequent:**	Standing, sitting, walking

RECEIPT AND REVIEW OF FUNCTIONAL JOB REQUIREMENTS

I, _____, have read, understand and agree to the above functional job description. I understand the essential functions, qualifications, education, experience, and physical demands of the position and acknowledge that I am capable of performing all of the essential functions of this position without reasonable accommodation or I have informed you of my need for an accommodation. I understand

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Signature _____ Date _____

Witness _____ Date _____

Behavioral Health Partners
METROWEST

BHPMW, LLC FUNCTIONAL JOB DESCRIPTION

Job Classification:	LMHP **Clinical Care Manager**
Reports to:	**Behavioral Health Community Partners Program Manager**
Supervises:	**Care Coordinators**
FLSA Status:	**Exempt**

Job Summary:

The Clinical Care Manager is assigned to Enrollees. The CCM provides direct CP supports and activities to Assigned and Engaged Enrollees and supervises a team of Care Coordinators within the assigned BHPMW BHCP consortium entity (CE) or Affiliated Partner (AP).

Essential Functions:

1. With the BHCP Program Manager hire, train and supervise BHCP Care Coordinators.
2. Motivate and lead a high performance team; provide supervision, mentoring and professional development opportunities.
3. Collaborate with team members to implement measures that decrease episodic care and meet quality outcomes.
4. Coordinates either directly or through the supervision of Care Coordinators, all aspects of CP service delivery with team members.
5. Utilize effective, dignified, empowering and creative engagement strategies to ensure Enrollees are at the center and lead in their BHCP services.
6. Conduct outreach and engagement activities with Assigned Enrollees and engage them in enrolling in the BHCP program, and supervise Care Coordinators in providing this CP support.
7. Complete comprehensive assessment in a collaborative manner with Engaged Enrollees, with input from Care Team members and other stakeholders. Conduct annual re-assessments. Supervise Care Coordinators in performing these functions related to assessments. Review all assessments completed by Care Coordinators.
8. Develop a person-centered treatment plan with each Engaged Enrollee, with input from Care Team members and other stakeholders. Update the treatment plan according to required timeframes. Supervise Care Coordinators in performing these functions related to treatment plans.
9. Develop advanced directors, acute care plans, and/or crisis plans with Engaged Enrollees as needed. Supervise Care Coordinators in developing these plans.
10. Work with Engaged Enrollees to assemble Care Teams and facilitate all communication and coordination with the team. Supervise Care Coordinators in performing these functions related to Care Teams.
11. Support Engaged Enrollees during care transitions including attendance at discharge planning meetings, face to face meetings post discharge, ensuring linkages with all needed services and supports, and facilitating Enrollee participation in those services. Supervise Care Coordinators in performing these functions related to care transitions.
12. Assist the RN with medication reconciliation functions as needed and requested, such as information collection.
13. Provide health and wellness coaching to Engaged Enrollees and assist them identifying and utilizing health and wellness supports in the community. Supervise Care Coordinators in performing these functions related to health and wellness.

14. Connect Engaged Enrollees to all needed services and supports including those that address social needs that affect health. Facilitate ongoing connection. Supervise Care Coordinators in performing these functions related to connecting to needed services.
15. Collaborate with existing providers, Care Team members, state agency staff, and all other stakeholders and delivers CP supports and activities in accordance with Enrollee's person centered treatment plan. Supervise Care Coordinators in performing these functions related to these functions.
16. Participate in BHCP team meetings and each Engaged Enrollee's Care Team to ensure effective communication among all disciplines and stakeholders involved in the person's care.
17. Identify community resources and develop natural supports for Enrollees and supervise Care Coordinators in performing these functions.
18. Participate in all required orientation and training. Train Care Coordinators and other CP Team members.
19. Learn all BHCP policies, procedures, protocols and plans and deliver CP supports and activities in compliance with them. Ensure all CP Team members are trained and comply with these protocols.
20. Develop knowledge about all focus populations and assist CP Team members in doing so.
21. Learn evidence based practices identified by the BHC, and deliver CP supports and activities in compliance with them, and ensure all CP Team members are trained and supported in implementing them.
22. Complete all required documentation in a timely manner.
23. Attend and actively participate in supervision and staff meetings.
24. Consults with RNs and other CP Team members as needed around clinical, medical and other matters.
25. Provide on-call coverage, as needed.
26. Ensure that all clients are treated with dignity and respect in accordance with BHPMW's Human Rights policy.
27. Perform all duties in accordance with the agency's policies and procedures.
28. Strictly follow all agency Performance Standards.

Please note: The essential functions listed in this section are not limited only to the tasks listed and may include other duties as assigned.

Qualification/Education/Experience:

1. Master's degree in social work, mental health counseling or related field with minimum of 4 years' experience working with adults in a community-based and/or medical setting.
2. Massachusetts independent clinical license required
3. One to two years' supervisory experience, preferred.
4. Demonstrated knowledge base and judgment necessary for independent clinical decision making.
5. One to two years professional and clinical experience in the areas of mental health, counseling, and substance use.
6. Strongly prefer that a candidate will have a demonstrated understanding of and competence in serving culturally diverse populations.
7. Excellent interpersonal skills and demonstrated ability to interact professionally with culturally and educationally diverse staff and patients.
8. Creativity, flexibility, sound judgment, and the ability to take initiative.
9. Excellent time management and organizational skills.
10. Strong communication and writing skills.
11. Demonstrated ability to work as an effective team member and leader in a complex and fast-paced environment.

12. Knowledge regarding psychiatric rehab and understanding of recovery model.
13. Must be able to perform each essential duty satisfactorily.
14. Must hold a valid drivers' license. Must have access to an operational and insured vehicle and be willing to use it to transport members.
15. Ability to read and speak English.

Physical Demands:

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

General requirements:

3. Full upper extremity range of motion
4. Full lower extremity range of motion

***Continuous:**	Communication
***Frequent:**	Standing, sitting, walking

RECEIPT AND REVIEW OF FUNCTIONAL JOB REQUIREMENTS

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Signature _____ Date _____

Witness _____ Date _____

Behavioral Health Partners
METROWEST

BHPMW, LLC FUNCTIONAL JOB DESCRIPTION

Job Classification:	**Data Analyst**
Reports to:	**Director of Population Health/Quality Management and dual report to Data Analytics Director**
FLSA Status:	**Exempt**

Job Summary:
The BHPMW BHCP Data Analyst assists with data collection, analyzes data and creates reports.

Essential Functions:

1. Assists Data Analytics Director, Director of Population Health/QM and program leadership to design meaningful monitoring and alert systems, dashboards and outcomes reports.
2. Generates and distributes various routine reports to support quality assurance and improvement initiatives.
3. Use statistical analysis, simulation, and optimization to analyze information and develop practical solutions.
4. Facilitates efforts to improve data capture and quality. Participates in collaboration to improve the quality of QM data.
5. Provides preliminary analyses of data including trends and relationships. Facilitates further analyses of that data with the data customers.
6. Interacts with vendors of software containing QM data in collaboration with Information Technology (IT) and Data Management (DM) staff and leaders.
7. As directed by the Director of Population Health/QM, works with funders, vendors, partners, and others to resolve data reporting problems and optimize data capture in collaboration with DM.
8. Manage project tasks to ensure project meets targeted completion date.
9. Attend and actively participates in supervision and team meetings.
10. Ensure that individuals we support are treated with dignity and respect in accordance with BHPMW Human Rights Policy.
11. Perform all duties in accordance with the agency's policies and procedures.
12. Strictly follow all agency performance standards.
13. Develops ad-hoc reports as requested

Please note: The essential functions listed in this section are not limited only to the tasks listed and may include other duties as assigned.

Qualification/Education/Experience:

1. Master's Degree or equivalent experience. Strongly prefer master's degree in information systems or related quantitative field (Business, finance, computer, science, or mathematics)
2. 3-5 years data analysis experience in a healthcare setting
3. Working knowledge of the community services/healthcare business
4. Strong math and analytical skills
5. Knowledge of Excel and relational databases required
6. Knowledge of analytical software, such as SPSS preferred
7. Understanding of managed care/ACO business a plus

8. Strong understanding of financial and outcomes management
9. Excellent interpersonal and verbal/written skills
10. Ability to maintain attendance to support required quality and quantity of work
11. Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
12. Ability to establish and maintain positive and effective work relationships with co-workers, persons served, and partners
13. Must be able to perform each essential duty satisfactorily
14. Must be able to work independently as well as function in a team atmosphere
15. Strong analytical, numerical and reasoning abilities
16. Superior communication skills including writing and verbal skills
17. High energy level, superior interpersonal skills

Physical Demands:

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

General requirements:

3. Full upper extremity range of motion

***Continuous:** Communication

RECEIPT AND REVIEW OF FUNCTIONAL JOB REQUIREMENTS

I, _____, have read, understand and agree to the above functional job description. I understand the essential functions, qualifications, education, experience, and physical demands of the position and acknowledge that I am capable of performing all of the essential functions of this position without reasonable accommodation or I have informed you of my need for an accommodation. I understand that the contents as presented are a matter of information and should in no way be construed as a contract between BHPMW LLC and its employees. BHPMW LLC reserves the right to change any part of this job description, as circumstances require.

Signature_____Date_____

Witness_____Date_____

Behavioral Health Partners
METROWEST

BHPMW, LLC FUNCTIONAL JOB DESCRIPTION

Job Classification:	**IT Services Staff**
Reports to:	**Director of Information Technology**
FLSA Status:	**Non-Exempt**

Job Summary:
The IT Services Staff is responsible for phone, email, training, and walk-in support for BHPMW program staff. Day to day tasks include logging and recording trouble issues, resolving problems over the phone, email, and in person as well as helping track and ensure that service requests are followed through resolution. Functions as subject matter expert supporting the BHPMW BHCP's care management software. Serves as liaison between BHPMW program staff and Advocates IT Department staff as needed.

Essential Functions:

1. Provide 1st tier technical support for BHPMW program staff.
2. Develop deep working knowledge of the BHPMW BHCP's care management software.
3. Function as key contact with care management software vendor, in collaboration with IT Director.
4. Provide training to end users as needed.
5. Install hardware, software, and peripheral equipment, to include workstations, printers, and monitors.
6. Maintain necessary documentation regarding installs and repairs.
7. Provide follow-up with end users to ensure satisfaction.
8. Attends and actively participates in supervision and team meetings.
9. Ensure that individuals are treated with dignity and respect in accordance with BHPMW Human Rights Policy.
10. Perform all duties in accordance with the agency's policies and procedures

Please note: The essential functions listed in this section are not limited only to the tasks listed and may include other duties as assigned

Qualification/Education/Experience:

1. High School Diploma or GED and 1-3 years of experience in the field or in a related area.
2. Must be able to perform each essential duty satisfactorily.
3. Familiar with and working knowledge of applications such as Microsoft Windows, Microsoft Office, computer hardware, and network security.
4. Excellent organizational skills and planning details.
5. Ability to work under time constraints and manage multiple projects simultaneously.
6. Demonstrated ability to work collaboratively as well as independently and consistently meet deadlines.
7. Capacity to orally communicate with clarity and accuracy with individuals and groups.
8. Must hold a valid drivers' license. Must have access to an operational and insured vehicle.
9. The ability to travel, with advanced notice and scheduling, to sites throughout Massachusetts.
10. High energy level, superior interpersonal skills and ability to function in a team atmosphere.
11. Must possess the ability to read and speak English.

Physical Demands:
General requirements:

1. Full upper extremity range of motion
2. Full lower extremity range of motion
3. Ability to lift at least 50 pounds in order to move equipment, cases of paper, etc.

***Continuous:**	Hearing, talking, sitting, handling, pushing, repetitive motions,
***Frequent:**	Standing, walking, hearing, lifting, balancing, stooping, bending carrying, kneeling
***Occasional:**	Reaching with hands and arms, stooping and crouching

RECEIPT AND REVIEW OF FUNCTIONAL JOB REQUIREMENTS

I, _____, have read, understand and agree to the above functional job description. I understand the essential functions, qualifications, education, experience, and physical demands of the position and acknowledge that I am capable of performing all of the essential functions of this position without reasonable accommodation or I have informed you of my need for an accommodation. I understand that the contents as presented are a matter of information and should in no way be construed as a contract between BHPMW LLC and its employees. BHPMW LLC reserves the right to change any part of this job description, as circumstances require.

Signature_____Date _____

Witness_____Date _____

Behavioral Health Partners
METROWEST

BHPMW, LLC FUNCTIONAL JOB DESCRIPTION

Job Classification:	**Peer Specialist / Recovery Coach / or Family Partner**
Reports to:	**Behavioral Health Community Partners Program Manager**
FLSA Status:	**Exempt**

Job Summary:

The Peer Specialist / Recovery Coach / or Family Partner will provide work with the Behavioral Health Community Partners (BHCP) team to support Enrollees participating in CP supports and activities. A Peer Specialist will also assist with the development of the BH CP Consumer Advisory Council in the first year of operation.

Essential Functions:

1. Utilize effective, dignified, empowering and creative engagement strategies to ensure Enrollees are at the center and lead in their BHCP services.
2. Model recovery principles and practices within the BHCP Team.
3. Provide support to outreach, engage and assist enrollees in identifying their recovery goals and developing recovery plans.
4. Provide linkages to recovery-oriented, peer support self-help supports and services and community based mental health, substance use disorder, and family supports programs.
5. Provide assistance with navigating the healthcare system and provide support/assistance with transitions in care.
6. Provide support to individuals while they are in the hospital, detoxification programs, 24-hour levels of care and other levels of care, emergency departments, and out-of-home placements as well as selfhelp groups and 12-step programs.
7. Provide assistance with solving problems directly related to recovery, including finding sober housing, making friends, finding new uses of spare time, and improving one's job skills.
8. Provide health and wellness coaching to Engaged Enrollees and assist them identifying and utilizing health and wellness supports in the community.
9. Participate in all required orientation and training.
10. Learn all BHCP policies, procedures, protocols and plans and deliver support to Enrollees in compliance with them.
11. Develop knowledge about all focus populations.
12. Learn evidence based practices identified by the BHCP and deliver services in compliance with them.
13. Assist with identifying and engaging Consumer Advisory Board members and support them in their participation.
14. Actively participate in team meetings and supervision to ensure effective communication.
15. Complete all required documentation in a timely manner in accordance with department, agency and contractual guidelines and requirements.
16. Advocate for individual's needs within the program as well as with external agencies.
17. Ensure that individuals receiving services are treated with dignity and respect in accordance with BHPMW's Human Rights Policy.
18. Perform all duties in accordance with the agency's policies and procedures.
19. Strictly follow all agency Performance Standards.

Please note: The essential functions listed in this section are not limited only to the tasks listed and may include other duties as assigned.

Qualification/Education/Experience:

1. Training and certification appropriate to the role; recovery coach or certified peer specialist or family partner training is preferred. If candidate does not have relevant training/certification at the time of hire, training will be arranged by BHPMW and will be required within 6 months of hire.
2. Must have lived experience with mental health, substance use conditions, or family supporting a family member with behavioral health challenges; and be in recovery, if applicable. Prefer current or former recipient of behavioral health services.
3. Ability to use an Electronic Health Record to document medically necessary clinical services.
4. Must be able to perform each essential duty satisfactorily.
5. Ability to communicate effectively verbally and in writing.
6. Strongly prefer that a candidate will have a demonstrated understanding of and competence in serving culturally diverse populations
7. Must have valid driver's license and access to auto.
8. Ability to read and speak English.

Physical Demands:

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

General requirements:

1. Full upper extremity range of motion
2. Full lower extremity range of motion

***Continuous:**	Communication
***Frequent:**	Standing, sitting, walking

RECEIPT AND REVIEW OF FUNCTIONAL JOB REQUIREMENTS

I, _____, have read, understand and agree to the above functional job description. I understand the essential functions, qualifications, education, experience, and physical demands of the position and acknowledge that I am capable of performing all of the essential functions of this position without reasonable accommodation or I have informed you of my need for an accommodation. I understand that the contents as presented are a matter of information and should in no way be construed as a contract between BHPMW, LLC and its employees. BHPMW, LLC reserves the right to change any part of this job description, as circumstances require.

Signature _____ Date _____

Witness _____ Date _____

Behavioral Health Partners
METROWEST

BHPMW, LLC FUNCTIONAL JOB DESCRIPTION

Job Classification:	**Quality Manager**
Reports to:	**Behavioral Health Community Partner (BHCP) Program Manager**
FLSA Status:	**Exempt**

Job Summary:
The Quality Manager is responsible for ensuring the implementation of the BHPMW BHCP's quality improvement plan within the assigned consortium entity (CE) or affiliated partner (AP) provider agency.

Essential Functions:

1. Develop, implement, and monitor, in collaboration compliance, the BHCP Program Manager and the BHCP Director of Population Health and Quality Management on-site systems that track and monitor internal and external quality measures, and includes procedures for quality assurance and improvement.
2. Ensure implementation of BHPMW BHCP's annual quality improvement plan, quality improvement activity, and other components of the quality program within the BHCP program at the assigned CE or AP agency.
3. Facilitate flow of quality related data and information to and from the BHPMW BHCP and the assigned CE or AP agency.
4. Serve as a member of the BHPMW BHCP's Quality Management Committee. Bring all outcomes of that committee to the BHCP at the assigned CE or AP agency.
5. Implement metrics and performance targets that assess compliance with the BHCP program and quality on-site at their respective agency. Conduct chart review and other data collection. Facilitate the CP Team's participation in the Engaged Enrollee satisfaction survey.
6. Facilitate reporting and tracking of grievances and critical incidents. Monitor external and internal investigations and conduct investigations as needed.
7. Maintain documentation/reporting related to performance oversight, including but not limited to schedules of audit and monitoring activities, and follow-up with corrective actions
8. Participate in all required orientation and training.
9. Learn all BHCP policies, procedures, protocols and plans appropriate to the Quality Manager position.
10. Develop knowledge about all focus populations and assist CP Team members in doing so.
11. Learn evidence based practices identified by the BHCP and support CP Team members in implementing them.
12. Attend and actively participate in supervision and staff meetings.
13. Ensure that all clients are treated with dignity and respect in accordance with BHPMW's Human Rights policy.
14. Perform all duties in accordance with the agency's policies and procedures.
15. Strictly follow all agency Performance Standards.

Please note: The essential functions listed in this section are not limited only to the tasks listed and may include other duties as assigned.

Qualification/Education/Experience:

1. MA/MS degree in Social Work or related field and 3 years' experience in Human Services quality/risk management.
2. Must be able to perform each essential duty satisfactorily.
3. Ability to communicate effectively in writing and ability to use good judgment.
4. Ability to read English and communicate effectively in the primary language of the programs as assigned.
5. Must possess excellent assessment and interviewing skills
6. Strong analytical, numerical and reasoning abilities.
7. Ability to manage multiple complex projects in varying stages of development.
8. Must have strong knowledge of computers.
9. Strongly prefer that a candidate will have a demonstrated understanding of and competence in serving culturally diverse population.
10. High energy level, superior interpersonal skills, and ability to work independently and function in a team atmosphere.
11. Ability to execute a variety of decision-making models.
12. Must hold a valid driver's license. Must have access to an operational and insured vehicle and be willing to use it to transport clients.

Physical Demands:

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

General requirements:

1. Full upper extremity range of motion
2. Full lower extremity range of motion

***Continuous:**	Communication
***Frequent:**	Standing, sitting, walking
***Occasional:**	Reaching with hands and arms, stooping and crouching

RECEIPT AND REVIEW OF FUNCTIONAL JOB REQUIREMENTS

I, _____, have read, understand and agree to the above functional job description. I understand the essential functions, qualifications, education, experience, and physical demands of the position and acknowledge that I am capable of performing all of the essential functions of this position without reasonable accommodation or I have informed you of my need for an accommodation. I understand that the contents as presented are a matter of information and should in no way be construed as a contract between BHPMW, LLC and its employees. BHPMW, LLC reserves the right to change any part of this job description, as circumstances require.

Signature _____ Date _____

Witness _____ Date _____

Behavioral Health Partners
METROWEST

BHPMW, LLC FUNCTIONAL JOB DESCRIPTION

Job Classification: **Registered Nurse Clinical Care Manager**
Reports to: **Behavioral Health Community Partner Program Manager**
FLSA Status: **Exempt**

Job Summary:
The Registered Nurse (RN) participates in the coordination of medical, behavioral health/addiction treatment services and other supports in accordance with the person-centered treatment plan, and works collaboratively with the BHCP team at their respective agency to manage or co-manage complex behavioral health cases. As a member of the multidisciplinary team, the RN provides consultation, education, and support to team members and provider network regarding co-occurring medical issues related to behavioral health/substance abuse treatment and management.

Essential Functions:

25. Provide medical consultation to BHCP team members in the assigned consortium entity (CE) or affiliated partner (AP) agency.
26. Liaison to and consult with the BHPMW BHCP Medical Director.
27. Conduct medication reconciliation functions required in the BHCP Model Contract.
28. In collaboration with the LMHP Clinical Care Manager, supervise Care Coordinators.
29. Provide CP supports to engaged enrollees with complex needs.
30. Review medical sections of Engaged Enrollee's comprehensive assessments, and/or the entire assessment as assigned.
31. Participate in BHCP team meetings to ensure effective communication among all disciplines.
32. Participate in all required orientation and training and assist with training other staff on the CP Team.
33. Learn all BHCP policies, procedures, protocols and plans and deliver services and consultation in compliance with them. Assist with training other staff on the CP Team.
34. Develop knowledge about all focus populations and assist CP Team members in doing so.
35. Learn evidence based practices identified by the BHC, and deliver CP supports and activities in compliance with them, and assist with training other CP Team members.
36. Complete all required documentation in a timely manner.
37. Attend and actively participate in supervision and staff meetings.
38. Ensure that all clients are treated with dignity and respect in accordance with BHPMW's Human Rights policy.
39. Perform all duties in accordance with the agency's policies and procedures.
40. Strictly follow all agency Performance Standards.

Please note: The essential functions listed in this section are not limited only to the tasks listed and may include other duties as assigned.

Qualification/Education/Experience:

12. BS in Nursing. Current registration in nursing from the Commonwealth of Massachusetts with minimum of 5 years direct working with adults in a community setting.
13. Demonstrated knowledge base and judgment necessary for independent clinical decision making.

14. Excellent verbal and written communications skills. Strong interpersonal and customer relations skills required.
15. Excellent organizational, time management and problem solving skills.
16. Basic computer knowledge.
17. Knowledge regarding psychiatric rehab and understanding of recovery model.
18. Strongly prefer that a candidate will have a demonstrated understanding of and competence in serving culturally diverse populations.
19. Must be able to perform each essential duty satisfactorily.
20. Must hold a valid drivers' license. Must have access to an operational and insured vehicle and be willing to use it to transport members.
21. Ability to read and speak English.

Physical Demands:

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

General requirements:

5. Full upper extremity range of motion
6. Full lower extremity range of motion

***Continuous:** Communication

***Frequent:** Standing, sitting, walking

RECEIPT AND REVIEW OF FUNCTIONAL JOB REQUIREMENTS

I, _____, have read, understand and agree to the above functional job description. I understand the essential functions, qualifications, education, experience, and physical demands of the position and acknowledge that I am capable of performing all of the essential functions of this position without reasonable accommodation or I have informed you of my need for an accommodation. I understand that the contents as presented are a matter of information and should in no way be construed as a contract between BHPMW, LLC and its employees. BHPMW, LLC reserves the right to change any part of this job description, as circumstances require.

Signature _____ Date _____

Witness _____ Date _____

F. Implementation Plan and Timeline

The implementation plan and timeline is included in attachments for this section.

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Domain*	Task	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Budget Preparation Period : August 2017 to									

Monthly Implementation Plan and Timeline: Budget Preparation Period

Domain*	Task	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Budget Preparation Period : August 2017 to March 2018									
Contracting and EOHHS contract management	Learn if awarded contract								
	Enter into contract negotiations with EOHHS								
	Execute contract with EOHHS								
	Provide EOHHS with contact info of staff to represent BHPMW & maintain financial records								
	Establish quarterly meeting with EOHHS								
	Develop & submit initial DSRIP Participation Plan								
	Obtain EOHHS approval of initial DSRIP Participation Plan								
	Participate in trainings, community forums, learning collaboratives, meetings, events requested by EOHHS								
	Successfully complete EOHHS Readiness Review								
	Enter into negotiations for contractual agreements with ACOs & MCOs								
	Execute contractual agreements with ACOs & MCOs								
Reporting	Establish reporting schedule with EOHHS								
	Develop report templates & workflows for Member Status Report, Quality Measures Report, & other reports as required								
Governance Structure	Finalize BHCP governance structure including Governing Body Executive Committee								
	Document policies regarding conflict resolution & contract oversite								
	Execute agreements/subcontracts/BAAs with CEs & AP								
	Establish schedule & conduct Governing Body Executive Committee meetings before & throughout contract term								
Implementation and Operations	Establish BHPMW BHCP implementation team, hold orientation meetings to establish work plan								
	Implement & monitor work plans to completion								
	Establish bimonthly BHPMW contract management meetings with each CE & AP to assess & support readiness activities								

Domain*	Task	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Budget Preparation Period : August 2017 to March 2018									

Domain*	Task	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Budget Preparation Period : August 2017 to									
Budget, Finance and Billing	Conduct financial consultation meeting with PCG								
	Submit a Budget Report & Budget Narrative for Budget Preparation Period to EOHHS for approval by date set by EOHHS								
	Submit a Budget Report & Budget Narrative for Budget Period 1 to EOHHS for approval								
	Receive DSRIP payment for Preparation Budget Period								
	Establish systems for accounting & financial management								
	Develop & process map the system for billing, payment and remit								
	Test billing system								
	Develop system to receive care coordination PMPM payments from EOHHS & reimburse CEs & AP for CP supports								
	Develop system to monitor DSRIP infrastructure spending and related reporting								
Information Technology	Confirm capability to meet all IT requirements including supporting statutory & regulatory requirements, sending & receiving MassHealth eligibility files & electronically storing Enrollee info								
	Develop policies & procedures for info sharing, EHR/care management system use & MA HIway connection, ensuring all exchanges are secure								
	Support CEs& AP in connecting to MA HI way as needed								
	Develop & maintain a care management system to document CP supports, Qualifying Activities, & Enrollee info in compliance with Model Contract								
	Develop & maintain internal to determine the validity & completeness of data submitted to EOHHS								
	Subscribe & connect to a statewide Event Notification System once developed by EOHHS								
	Equip staff with laptops and cell phones								

Domain*	Task	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Budget Preparation Period : August 2017 to March 2018									
Care Management Software	Finalize care management software selection & sign letter of intent								
	Execute contract with care management software vendor								
	Establish regular meetings with care management software vendor to customize & operationalize system								
	Finalize customization of care management software including reporting capacity								
	Test care management software								
	Train staff on care management software								
Interpreter and Translation Services software and/or other solutions	Analyze availability of software solutions & live solutions for interpreter & translation services								
	Execute contract(s) for software, language line, and/or other solutions for interpreter & translation services								
	Test software, language line, and/or other solution for interpreter & translation services								
	Train staff on solutions/systems								
Quality Improvement, Data Analytics and Compliance	Formalize membership of Quality Management Committee (QMC) & establish meeting schedule								
	Finalize QI plan & submit to EOHHS by date requested								
	Establish internal systems for outcomes measurement & data analytics consistent with BHCP metrics								
	Work with Compliance Officer and legal counsel to ensure all compliance issues are addressed								
	Confirm proposed quality initiative for Budget Period 1 & organize data tracking systems & orientation for staff & QMC								
Consumer Advisory Board (CAB)	Begin early identification of potential members of the Consumer Advisory Board								
	Establish CAB meeting schedule & locations								

Domain*	Task	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Budget Preparation Period : August 2017 to March 2018									

Domain*	Task	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Budget Preparation Period : August 2017 to									
Policies, Procedures, Protocols and Plans	Develop a conflict of interest policy; submit to EOHHS								
	Write & adopt formal Continuity of Operations Plan & submit to EOHHS upon request								
	Write grievance policy & procedures; submit to EOHHS								
	Develop protocol & materials to provide Enrollees with info on the grievance policy & procedures								
	Write Enrollee rights policy & procedures								
	Develop protocol & materials to provide Enrollees with info on the Enrollee rights policy & procedures								
	Write a protocol to track, review & report critical incidents & identify key personnel to implement & monitor protocol								
	Train staff on all policies, procedures, protocols, plans								
Community Collaboration and Coordination	Develop & maintain collaborative relationships with community based organizations & state agencies								
	Develop relationships with CBFS providers to coordinate care								
Workforce development	Finalize recruitment, orientation, training & hiring plan								
	Finalize curriculum development & operational staff training plan including dates & locations								
	Execute recruitment plan & activities to engage and hire staff								
	Hire Program Director								
	Hire Director of Population Health Management								
	Hire all remaining staff consistent with staffing rations based on volume ramp up projections								
	Conduct centralized initial orientation & training for all on boarded staff across the CP								
	Load video of trainings to web-based learning solution for ongoing access.								

Domain*	Task	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Budget Preparation Period : August 2017 to March 2018									

Domain*	Task	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Budget Preparation Period : August 2017 to									
Community Partner Supports	Document policies & procedures for triage & Enrollee assignment								
	Develop protocols for outreach & engagement								
	Develop protocols for Comprehensive Assessment & Person-Centered Treatment Planning								
	Finalize Assessment tool & treatment plan for programming in care management software								
	Develop protocols for Care Coordination & Care Management								
	Develop protocols for Care Transitions								
	Develop protocols for Medication Reconciliation								
	Develop protocols for Health & Wellness Coaching								
	Identify health and wellness resources; plan programs								
	Develop protocols for Connection to Community, Social & Flexible Services including follow up to ensure Engaged Enrollees are obtaining needed services as indicated by the treatment plan								
	Develop extensive network of resources including BH, medical & social services; identify gaps in Service Areas & expand existing affiliations; utilize BHPMC database of CF								
	Develop protocols for recommending Flexible Services to Engaged Enrollee's ACO								
	Develop protocols for provision of CP Supports to Enrollees with BH & LTSS needs								
	Train staff on all protocols & resources.								
Community Education and Marketing	Develop brochures & other written materials for enrollees consistent with program operations in multilingual and alternative formats								
	Develop written materials for primary care & specialty medical providers consistent with program operations								
	Develop website								

Domain*	Task	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Budget Preparation Period : August 2017 to March 2018									
Community Education and Marketing (continued)	Establish individual outreach & informational meetings for area stakeholders e.g., ACO, MCO, potential qualitative referral sources								
	Visit primary care practices to introduce the BHCP, foster relationships, develop protocols for collaborating on Care Teams, treatment plans & ongoing care coordination.								
	Outreach to Enrollees with pre-existing relationships with the CEs & AP who may be eligible for CP supports to educate about the CP program & how to enroll after contract start date								

*** A primary domain was selected for each task, recognizing that some tasks address more than one domain.**

Quarterly Implementation Plan and Timeline: Budget Periods 1-5

Domain	Task	Q1	Q2	Q3	Q4
	Budget Period 1: April 2018-December 2018				
	Participate in quarterly meetings with EOHHS				
Contracting and EOHHS contract management	Provide EOHHS with performance report 7 days prior to quarterly meetings				
	Participate in trainings, community forums, learning collaboratives, meetings, and events as requested by EOHHS				
	Establish regular meetings with ACOs and MCOs with contractual agreem with BHCP				
	Submit monthly member status report				
Reporting	Notify EOHHS, ACOs, MCOs of capacity to take new referrals in CP				
	Submit all quarterly reporting to EOHHS				
	Submit Semiannual Progress Report to EOHHS by date determined by EOHHS				
Governance	Report all data related to Quality Score and DSRIP Accountability Score				
Structure	Conduct quarterly Governing Body Executive Committee meetings				
Implementation and Operations	Begin BHCP operations				
	Accept Assigned Enrollees to meet or exceed value projections for Budget Period 1				
	Hold bimonthly to quarterly BHPMW contract management meetings wit each CE & AP to review data, performance & contract compliance & develop improvement plans as needed				
	If CE Advocates becomes contracted as an LTSS CP via another bid, establish protocols and mechanisms for collaboration between the BH ar LTSS CPs.				
Budget, Finance and Billing	Process monthly billing in a timely & efficient manner across CP				
	Receive care coordination PMPM payments from EOHHS & reimburse CEs & AP for CP supports				
	Implement system to monitor DSRIP infrastructure spending and related reporting				
	Conduct financial consultation meeting with PCG				
	Submit a Budget Report & Budget Narrative for Budget Period 2 to EOHHS for approval				
Information Technology	Revise DSRIP Participation Plan & resubmit to EOHHS for approval upon s cant changes				
	Assess Engaged Enrollee needs & research Mobile Health Applications to implement in Period 2				
	Maintain a care management system to document CP supports, Qualifying Activities, & Enrollee info in compliance with Model Contract				
	Maintain processes to determine the validity & completeness of data sub ed to EOHHS				

Domain	Task	Q1	Q2	Q3	Q4
	Subscribe & connect to a statewide Event Notification System once developed by EOHHS				
	Implement care management software				
Care Management Software	Continue regular meetings with care management software vendor to operationalize system				
	Provide ongoing staff training on system and any enhancements				
	Budget Period 1: April 2018-December 2018 (continued)				
Interpreter and Translation Services and/or other solutions	Implement software, language line, and/or other solution for interpreter & translation services **software**				
	Provide ongoing staff training on system & any enhancements				
Quality Improvement, Data Analytics and Compliance	Conduct quarterly Quality Management Committee (QMC) meetings				
	Submit annual QI Plan to EOHHS				
	Train QMC & staff on QI Plan and Plan Do Study Act QCI model				
	Implement QI Plan				
	Implement quality initiative for Budget Period 1, train staff on related best practices, track data, measure progress, bring data to QMC & CAB				
	Evaluate fidelity & impact of Evidence Based Practices & best practices, provide continued training, continue to identify & integrate additional				
	Work with Compliance Officer & legal counsel to ensure all compliance issues are addressed				
	Implement internal systems for outcomes measurement & data analytics consistent with BHCP metrics				
	Participate in EOHHS administered Engaged Enrollee experience survey				
	Meet with EOHHS at least annually to review progress in meeting quality & accountability measures				
	Establish quality initiative for Budget Period 2				
	Recruit CAB members				
Consumer Advisory Board (CAB)	Conduct quarterly CAB meetings				
	Track CAB activities for inclusion in BHCP's Annual Report to EOHHS				
Policies, procedures, protocols, plans	Implement all policies, procedures, protocols, and plans				
	Track & report grievances, review data at QMC				
	Track & report critical incidents				
	Deliver all CP Supports & implement all CP supports protocols				
	Implement health & wellness programs				
Community Partner Supports	Update network of resources & ensure staff access				
	Implement protocols for recommending Flexible Services to Engaged				

	Enrollee's ACO				
	Continue to train staff on protocols & resources				
	Continue to recruit, hire, orient & train staff consistent with volume proje s & ramp up plan				
Workforce Development	Conduct orientation & training for newly on boarded staff				
	Conduct ongoing training for all staff consistent with training plan				
Community Partnerships and Resources	Update collaborative relationships with community based organizations & state agencies				
	Identify gaps in resources based on Engaged Enrollees and care coordina feedback and locate resources to address needs				

Budget Period 1: April 2018-December 2018 (continued)

	Go live with website				
	Continue to conduct individual outreach & informational meetings for ar stakeholders e.g., ACOs, MCOs, potential qualitative referral sources				
Community Education and Marketing	Identify PCPs with high volume of Engaged Enrollees & conduct visits introduce the BHCP, foster relationships, develop protocols for collaborating on Care Teams, treatment plans & ongoing care coordinati				
	Continue to outreach to Enrollees with pre-existing relationships with the CEs & AP who may be eligible for CP supports to educate about the CP program & how to enroll				

Domain	Task	Q1	Q2	Q3	Q4
	Budget Period 2: January 2019 to December 2019				
Contracting and EOHHS contract management	Participate in quarterly meetings with EOHHS				
	Provide EOHHS with performance report 7 days prior to quarterly meetings				
	Participate in trainings, forums, learning collaboratives, meetings, & events as requested by EOHHS				
	Continue regular meetings with ACOs and MCOs with contractual agreements with BHCP				
	Submit monthly member status report				
	~~Notify EOHHS, ACOs, MCOs or capacity to take new referrals in CP~~				
	Submit all quarterly reporting to EOHHS				
Reporting	Submit Annual Report for Budget Period 1 within 60 days of end of that Period				
	Submit Semiannual Progress Report to EOHHS by date determined by EOHHS				
	~~Report all data related to Quality Score and DSRIP Accountability Score~~				
Governance Structure	Conduct quarterly Governing Body Executive Committee meetings				
Implementation and Operations	Continue to accept Assigned Enrollees to meet or exceed value projections for Budget Period 2				
	Hold bimonthly to quarterly BHPMW contract management meetings with each CE & AP to review data, performance & contract compliance & develop improvement plans as needed				
	Process monthly billing in a timely & efficient manner across CP				
Budget, Finance and Billing	Receive care coordination PMPM payments from EOHHS & reimburse CEs & AP for CP supports				
	~~Manage system to monitor DSRIP infrastructure spending and related~~ reporting				
	Conduct financial consultation meeting with PCG				
	Submit a Budget Report & Budget Narrative for Budget Period 3 to EOHHS for approval				
	Revise DSRIP Participation Plan & resubmit to EOHHS for approval upon significant changes				
Information Technology	Maintain a care management system to document CP Supports, Qualifying Activities, & Enrollee info in compliance with Model Contract				
	Maintain processes to determine the validity & completeness of data submitted to EOHHS				
	Subscribe & connect to a statewide Event Notification System once developed by EOHHS				
	Continue regular contact with care management software vendor to				

Domain	Task	Q1	Q2	Q3	Q4
Care Management Software	monitor system and address needs				
	Provide ongoing staff training on system & any enhancements				
Interpreter and Translation Services	Utilize software, language line, and/or other solution for interpreter & translation services				
	Provide ongoing staff training on system & any enhancements				

Domain	Task	Q1	Q2	Q3	Q4
	Budget Period 2: January 2019 to December 2019 (continued)				
	Conduct quarterly Quality Management Committee (QMC) meetings				
	Submit annual QI Plan to EOHHS Train				
	QMC & staff on the year's QI Plan				
	Implement QI Plan				
	Implement quality initiative for Budget Period 2, train staff on related				
	best practices, track data, measure progress, and bring data to QMC &				
	CAB				
Quality	Evaluate fidelity & impact of Evidence Based Practices & best practices,				
Improvement, Data	~~provide continued training, continue to identify & integrate additional~~				
Analytics and	practices				
	Work with Compliance Officer & legal counsel to ensure all compliance				
Compliance	issues are addressed				
	Utilize internal systems for outcomes measurement & data analytics				
	consistent with BHCP metrics				
	~~Participate in EOHHS administered Engaged Enrollee experience survey~~				
	Meet with EOHHS at least annually to review progress in meeting				
	quality & accountability measures				
	~~Establish quality initiative for Budget Period 3~~				
Consumer Advisory	Conduct quarterly CAB meetings				
Board (CAB)	Track CAB activities for inclusion in BHCP's Annual Report to EOHHS				
	Monitor adherence to all policies, procedures, protocols, plans, revising as needed				
Policies, procedures,	Track & report grievances, review data at QMC **protocols,**				
plans	Track & report critical incidents				
	Deliver all CP Supports & utilize all CP supports protocols, revising as				
	needed				
Community Partner	Update network of resources & ensure staff access				
Supports	Monitor implementation of protocols for recommending Flexible				
	Services to Enrollee's ACO				
	Continue to train staff on protocols & resources				
	Continue to recruit, hire, orient & train staff consistent with volume				
	projections & ramp up plan				
Workforce	Conduct orientation & training for newly on boarded staff				
Development					
Community	Update collaborative relationships with community based organizations				
Partnerships and	& state agencies				

Domain	Task	Q1	Q2	Q3	Q4
	Identify gaps in resources based on Engaged Enrollees & care				
Resources	coordinator feedback; locate resources to address needs				
Community	Continue to outreach to PCPs, ACOs, MCOs & potential qualitative				
Education and	referral sources				
	Update brochures & materials with outcomes data to demonstrate				
Marketing	value of BHCP				
	Budget Period 3: January 2020 to December 2020				
	Participate in quarterly meetings with EOHHS				
	Provide EOHHS with performance report 7 days prior to quarterly				
Contracting and	meetings				
EOHHS contract	Participate in trainings, community forums, learning collaboratives,				
management	meetings, and events as requested by EOHHS				
	Continue regular meetings with ACOs and MCOs with contractual agreements with BHCP				
	Submit monthly member status report				
	Notify EOHHS, ACOs, MCOs or capacity to take new referrals in CP				
	Submit all quarterly reporting to EOHHS				
	Submit Annual Report for Budget Period 2 within 60 days of end of that				
Reporting	Period				
	Submit Semiannual Progress Report to EOHHS by date determined by EOHHS				
	Report all data related to Quality Score and DSRIP Accountability Score				
	Conduct quarterly Governing Body Executive Committee meetings				
Governance	Devote an Executive Committee meeting to sustainability planning midway through Budget Period 3				
	Continue to accept Assigned Enrollees to meet or exceed value				
Implementation and	projections for Budget Period 3				
	Hold bimonthly to quarterly BHPMW contract management meetings				
Operations	with each CE & AP to review data, performance & contract compliance				
	& develop improvement plans as needed				
	Process monthly billing in a timely & efficient manner across CP				
	Receive care coordination PMPM payments from EOHHS & reimburse CEs & AP for CP supports				
	Manage system to monitor DSRIP infrastructure spending and related				
Budget, Finance and	reporting				
Billing	Conduct financial consultation meeting with PCG				
	Submit a Budget Report & Budget Narrative for Budget Period 4 to EOHHS for approval				

Response to request f

Domain					
	Revise DSRIP Participation Plan & resubmit to EOHHS for approval upon significant changes				
Information Technology	Maintain a care management system to document CP supports, Qualifying Activities, & Enrollee info in compliance with Model Contract				
	Maintain processes to determine the validity & completeness of data submitted to EOHHS				
	Subscribe & connect to a statewide Event Notification System once developed by EOHHS				
Care Management Software	Continue regular contact with care management software vendor to monitor system & address needs				
	Provide ongoing staff training on system and any enhancements				
Interpreter and Translation Services	Utilize software, language line, and/or other solution for interpreter & translation services				
	Provide ongoing staff training on system & any enhancements				

Budget Period 3: January 2020 to December 2020 (continued)

Quality Improvement, Data Analytics and Compliance	Conduct quarterly Quality Management Committee (QMC) meetings				
	Submit annual QI Plan to EOHHS				
	Train QMC & staff on the year's QI Plan Implement				
	QI Plan				
	Implement quality initiative for Budget Period 3, train staff on best practices, track data, measure progress, and bring data to QMC & CAB				
	Evaluate fidelity & impact of Evidence Based Practices & best practices, provide continued training, continue to identify & integrate additional practices				
	Work with Compliance Officer & legal counsel to ensure all compliance issues are addressed				
	Utilize internal systems for outcomes measurement & data analytics consistent with BHCP metrics				
	Participate in EOHHS administered Engaged Enrollee experience survey				
	Meet with EOHHS at least annually to review progress in meeting quality and accountability measures				
	Establish quality initiative for Budget Period 4				
Consumer Advisory Board (CAB)	Conduct quarterly CAB meetings				
	Track CAB activities for inclusion in BHCP's Annual Report to EOHHS				

Domain	Task	Q1	Q2	Q3	Q4
Policies, procedures,	Monitor adherence to all policies, procedures, protocols, and plans, revising as needed **protocols, plans** Track & report grievances, review data at QMC				
	Track & report critical incidents				
Community Partner Supports	Deliver all CP Supports & utilize all CP supports protocols, revising as needed				
	Update network of resources & ensure staff access				
	Monitor implementation of protocols for recommending Flexible Services to Enrollee's ACO				
Workforce Development	Continue to train staff on protocols & resources				
	Continue to recruit, hire, orient & train staff consistent with volume projections & ramp up plan				
	Conduct orientation & training for newly on boarded staff				
	Conduct ongoing training for all staff consistent with training plan				
Community Partnerships and Resources	Update collaborative relationships with community based organizations & state agencies				
	Identify gaps in resources based on Engaged Enrollees & care coordinator feedback; locate resources to address needs				
Community Education and Marketing	Continue to outreach to PCPs, ACOs, MCOs & potential qualitative referral sources				
	Update brochures and materials with outcomes data to demonstrate value of BHCP				

Domain	Task	Q1	Q2	Q3	Q4
	Budget Period 4: January 2021 to December 2021				
Contracting and EOHHS contract management	Participate in quarterly meetings with EOHHS, introduce focus on sustainability planning				
	Provide EOHHS with performance report 7 days prior to quarterly meetings				
	Participate in trainings, community forums, learning collaboratives, meetings, and events as requested by EOHHS				
	Continue regular meetings with ACOs and MCOs with contractual agreements with BHCP, with specific focus on sustainability planning				
	Submit monthly member status report				
	Notify EOHHS, ACOs, MCOs or capacity to take new referrals in CP				
	Submit all quarterly reporting to EOHHS				
Reporting	Submit Annual Report for Budget Period 3 within 60 days of end of that Period				
	Submit Semiannual Progress Report to EOHHS by date determined by EOHHS				
	Report all data related to Quality Score and DSRIP Accountability Score				
	Conduct quarterly Governing Body Executive Committee meetings				
Governance	Include sustainability and transition planning on all Executive Committee meeting agendas				
	Continue to accept Assigned Enrollees to meet or exceed value projections for Budget Period 4				
Implementation and Operations	Hold bimonthly to quarterly BHPMW contract management meetings with each CE & AP to review data, performance & contract compliance & develop improvement plans as needed				
	Process monthly billing in a timely & efficient manner across CP				
	Receive care coordination PMPM payments from EOHHS & reimburse CEs & AP for CP supports				
	Manage system to monitor DSRIP infrastructure spending and related reporting				
Budget, Finance and Billing	Conduct financial consultation meeting with PCG				
	Submit a Budget Report & Budget Narrative for Budget Period 5 to EOHHS for approval				
	Revise DSRIP Participation Plan & resubmit to EOHHS for approval upon significant changes				
	Utilize Mobile Health Applications adding additional tools as needed & supported by available funding				
	Maintain a care management system to document CP supports,				

Domain					
Information Technology	Qualifying Activities, & Enrollee info in compliance with Model Contract Maintain processes to determine the validity & completeness of data submitted to EOHHS				
Care Management Software	Subscribe & connect to a statewide Event Notification System once developed by EOHHS Continue regular contact with care management software vendor to monitor system and address needs Provide ongoing staff training on system and any enhancements				
	Budget Period 4: January 2021 to December 2021 (continued)				
Interpreter and Translation Services	Utilize software, language line, and/or other solution for interpreter & translation services Provide ongoing staff training on system & any enhancements				
Quality Improvement, Data Analytics and Compliance	Conduct quarterly Quality Management Committee (QMC) meetings				
	Submit annual QI Plan to EOHHS				
	Train QMC & staff on the year's QI Plan				
	Implement QI Plan				
	Implement quality initiative for Budget Period 4, train staff on related best practices, track data, measure progress, bring data to QMC & CAB				
	Evaluate fidelity & impact of Evidence Based Practices & best practices, provide continued training, continue to identify & integrate additional practices				
	Work with Compliance Officer & legal counsel to ensure all compliance issues are addressed				
	Utilize internal systems for outcomes measurement & data analytics consistent with BHCP metrics				
	Participate in EOHHS administered Engaged Enrollee experience survey				
	Meet with EOHHS at least annually to review progress in meeting quality and accountability measures Establish quality initiative for Budget Period 5				
Consumer Advisory Board (CAB)	Conduct quarterly CAB meetings Track CAB activities for inclusion in BHCP's Annual Report to EOHHS				
Policies, procedures, protocols, plans	Monitor adherence to all policies, procedures, protocols, plans, revising as needed Track & report grievances, review data at QMC				

Domain	Task	Q1	Q2	Q3	Q4
	Track & report critical incidents				
	Deliver all CP Supports & utilize all CP supports protocols, revising as needed				
Community Partner	Update network of resources & ensure staff access				
Supports	Monitor implementation of protocols for recommending Flexible Services to Enrollee's ACO				
	Continue to train staff on protocols & resources				
Workforce Development	Continue to recruit, hire, orient & train staff consistent with volume projections & ramp up plan				
	Conduct orientation & training for newly on boarded staff				
	Conduct ongoing training for all staff consistent with training plan				
Community Partnerships and Resources	Update collaborative relationships with community based organizations & state agencies				
	Identify gaps in resources based on Engaged Enrollees & care coordinator feedback; locate resources to address needs				
Community Education and Marketing	Continue to outreach to PCPs, ACOs, MCOs & potential qualitative referral sources				
	Update brochures & materials with outcomes data to demonstrate value of BHCP				
	Budget Period 5: January 2022 to December 2022				
Contracting and EOHHS contract management	Participate in quarterly meetings with EOHHS, with major focus on sustainability & transition planning				
	Provide EOHHS with performance report 7 days prior to quarterly meetings				
	Participate in trainings, community forums, learning collaboratives, meetings, and events as requested by EOHHS				
	Continue regular meetings with ACOs and MCOs with contractual agreements with BHCP, with major focus on sustainability &transition planning				
	Submit monthly member status report				
	Notify EOHHS, ACOs, MCOs or capacity to take new referrals in CP				
	Submit all quarterly reporting to EOHHS				
	Submit Annual Report for Budget Period 4 within 60 days of end of that Period				
Reporting	Submit Semiannual Progress Report to EOHHS by date determined by EOHHS				
	Report all data related to Quality Score and DSRIP Accountability Score				
	Submit all reports for the end of the 5 year program as requested by EOHHS				

Domain	Task
Governance	Conduct quarterly Governing Body Executive Committee meetings Include sustainability & transition planning as primary agenda item for all Executive Committee meetings Create a Sustainability & Transition Team to meet monthly Develop a Sustainability & Transition Plan by end of first quarter for approval by Executive Committee an discussions with EOHHS, ACOs & MCOs
Implementation and Operations	Continue to accept Assigned Enrollees to meet or exceed value projections for Budget Period 5 Hold bimonthly to quarterly BHPMW contract management meetings with each CE & AP to review data, performance & contract compliance & develop improvement plans as needed, & focus on sustainability & transition planning for their CP teams & Engaged Enrollees
Budget, Finance and Billing	Process monthly billing in a timely & efficient manner across CP Receive care coordination PMPM payments from EOHHS & reimburse CEs & AP for CP supports Manage system to monitor DSRIP infrastructure spending and related reporting Conduct financial consultation meeting with PCG Revise DSRIP Participation Plan & resubmit to EOHHS for approval upon significant changes Submit all budget & financial reports for the end of the 5 year program as requested by EOHHS

Budget Period 5: January 2022 to December 2022 (continued)

Information Technology	Utilize Mobile Health Applications adding additional tools as needed & supported by available funding Develop sustainability plan for Mobile Health Applications and/or transition to modifications or discontinuation Maintain a care management system to document CP supports, Qualifying Activities, & Enrollee information in compliance with Model Contract Maintain processes to determine the validity & completeness of data submitted to EOHHS Subscribe & connect to a statewide Event Notification System once developed by EOHHS Continue regular contact with care management software vendor to monitor system and address needs
Care Management Software	Provide ongoing staff training on system and any enhancements

Domain	
	Develop sustainability plan for care management software and/or transition to modifications or discontinuation
Interpreter and Translation Services	Utilize software, language line, and/or other solution for interpreter &
	Provide ongoing staff training on system & any enhancements
	Develop sustainability plan for interpreter & translation services & tools and/or transition to modifications or discontinuation
Quality Improvement, Data Analytics and Compliance	Conduct quarterly Quality Management Committee (QMC) meetings
	~~Submit annual QI Plan to EOHHS~~
	~~Train QMC & staff on the year's QI Plan Implement QI Plan~~
	Implement quality initiative for Budget Period 5, train staff on best practices, track data, measure progress, and bring data to QMC & CAB
	Evaluate fidelity & impact of Evidence Based Practices & best practices, provide continued training, continue to identify & integrate additional practices
	Work with Compliance Officer & legal counsel to ensure all compliance issues are addressed
	~~Utilize internal systems for outcomes measurement & data analytics~~ consistent with BHCP metrics
	Participate in EOHHS administered Engaged Enrollee experience survey
	Meet with EOHHS at least annually to review progress in meeting quality and accountability measures
	Engage QMC in assessing, summarizing, & reflecting on the 5 year ~~program & hold final meeting~~
	~~Submit all reports related to quality, outcomes measurement, etc. for~~ the end of the 5 year program as requested by EOHHS Conduct quarterly CAB meetings
~~**Consumer Advisory**~~ **Board (CAB)**	~~Track CAB activities for inclusion in BHCP's Annual Report to EOHHS~~
	Engage CAB in assessing, summarizing, & reflecting on the 5 year program & hold final meeting
Policies, procedures,	Monitor adherence to all policies, procedures, protocols, and plans, revising as needed **protocols, plans** Track & report grievances, review data at QMC
	Track & report critical incidents

Budget Period 5: January 2022 to December 2022 (continued)

	Deliver all CP Supports & utilize all CP supports protocols, revising as needed
	Update network of resources & ensure staff access
Community Partner	Monitor implementation of protocols for recommending Flexible

Domain	Task	Q1	Q2	Q3	Q4
Supports	Services to Enrollee's ACO				
	Continue to train staff on protocols & resources				
	Inform Engaged Enrollees regarding sustainability & transition planning, supporting them with any necessary transitions in their services				
	Continue to recruit, hire, orient & train staff consistent with volume projections & ramp up plan				
Workforce Development	Conduct orientation & training for newly on boarded staff				
	Conduct ongoing training for all staff consistent with training plan				
	Inform & involve staff in a transparent manner regarding sustainability & transition planning, supporting staff with any necessary transitions in their jobs				
Community Partnerships and Resources	Update collaborative relationships with community based organizations & state agencies				
	Identify gaps in resources based on Engaged Enrollees & care coordinator feedback; locate resources to address needs				
	Inform & involve community partnerships in sustainability & transition planning				
Community Education and Marketing	Continue to outreach to PCPs, ACO, MCO, & potential qualitative referral sources				
	Update brochures and materials with outcomes data to demonstrate value of BHCP				
	Inform & involve PCPs & other community members in sustainability & transition planning				

G. Budget Report and Budget Narrative

The Budget Report and Budget Narrative, using Attachments B and C, are attached.
See Budget and Budget Narratives in the BH Attachment A with Staffing Template.

H. Sustainability

BHPMW BHCP will strive to sustainably fund the proposed infrastructure and capacity building investments and CP supports over the Contract Term and after the initial Contract Term.

During the five year Contract Term, BHCP will sustain funding of CP supports through meeting all contract requirements and appropriately maximizing revenue by: efficiently enrolling as many members as possible as quickly as possible into the BHCP; submitting a "Treatment Plan Complete" Qualifying Activity by the end of the third month after the Enrollee signs the participation form; conducting at least one Qualifying Activity for all Assigned and Engaged Enrollees per month and billing as allowed and required in the contract; and developing and managing accurate and efficient processes for billing of Qualified Activities. BHCP will sustain funding of the proposed infrastructure and capacity building investments through these mechanisms, thereby maximizing enrollment and infrastructure investments, and by timely and efficient implementation of all proposed infrastructure and capacity building projects.

BHPMW will be flexible in developing alternative funding mechanisms as the demonstration progresses and potential sustainability strategies unfold. Ultimately, the intent of MassHealth's waivers is to change the way the health care system does business, resulting in BHCPs and other providers achieving cost efficiencies during the five year demonstration period. Integral to this vision, if implemented as intended, the BHCP will significantly impact where and how high-cost Enrollees receive physical and behavioral health services and other supports, which is also expected to achieve cost savings. BHPMW BHCP's goal is to achieve these cost savings and assist the MCOs and ACOs to realize delivery system efficiencies in an amount greater than ongoing infrastructure costs.

As referenced in 7.3.J., BHPMW believes the key to achieving long term sustainability with the ACOs and MCOs is to demonstrate the BHCP's value through the work of the CP teams with the ACOs and MCOs members, their primary and specialty medical provider networks and their internal care management programs. As described in section 7.3.C., BHCP's engagement with PCPs, specialty providers, ACOs and MCOs begins prior to contract implementation and is integrated throughout BHCP's delivery of all the CP supports and activities. Through these efforts and good outcomes data, BHCP's goal is to demonstrate enough value to motivate the ACOs and MCOs to develop plans for sustaining CP supports or similar care coordination services after the five year period. Then, BHCP can work with MCOs and ACOs to develop new payment methodologies and/or contracts to sustain CP supports and infrastructure and capacity building investments after the initial Contract Term.

It is anticipated that during the initial Contract Term, the ACOs and MCOs will have already worked with BHCP and other providers to develop alternative payment methodologies (APM).

APMs could be created for care management services, direct BH services, or both, resulting in some or all these services being reimbursed in new ways after the Contract Term.

Contingency plans for sustainability

A contingency plan may be the continuation or restoration of care management contracts with the MCOs and potentially expanding these to the ACOs. As listed in 7.2.D., some of the CEs and AP are currently contracted to provide integrated care management services with Beacon/NHP Here For You, MBHP Practice Based Care Management and CeltiCare Health. It is unclear if these care management contracts will continue during the BHCP initial Contract Term, perhaps to serve these
MCOs' members who are not eligible or do not enroll in the BHCP program, or if the MCOs will discontinue these contracts. After the contract Term, these care management contracts and/or similar models could be continued, resumed, and/or expanded, and could serve as a platform onto which BHCP-like services could be shifted.

Another contingency plan could be utilizing the Community Support Program (CSP) covered service, for which four of the five CEs and AP are contracted, to continue a level of care coordination services for members who had been enrolled in the BHCP demonstration program. Enrollees in the BHCP could continue to receive some care coordination services billed through this MassHealth covered service.

A final contingency plan to help sustain infrastructure would be to seek grant funding. BHPMW has been successful to date in securing such funding from various sources to begin to build the LLC's infrastructure to position the entity to bid on the BHCP contract. It is not expected that grant funding would be a stand-alone solution or even a primary funding source for sustaining CP supports or infrastructure. Foundations would not be a likely source to support ongoing CP operations; however, some foundations tend to support infrastructure and capacity building. Some could be interested in short term funding to support the development of specific APMs.

Structures and processes for sustainability and transition planning

BHPMW BHCP Governing Body Executive Committee and leadership staff understand that planning for sustainability must begin from the beginning of this initiative. Particular structures for sustainability planning will include ongoing financial consultation with Public Consulting Group and an Executive Committee meeting that will be devoted to this topic mid-way through Budget Period 3. At the beginning of Budget Period 4, BHCP will include this topic in all Executive Committee meetings, quarterly meetings with EOHHS and ongoing meetings with ACOs and MCOs.

In Budget Period 5, major attention needs to be paid not only to sustainability planning but also to transition planning, e.g., transitioning Enrollee CP supports to whatever programmatic model, alternative payment methodology, contract, program, and/or providers that will be in place after the five year waiver program ends. Planning will also likely need to be done around staff transitions. BHCP will convene a Sustainability and Transition Team at the beginning of the last budget period that will meet monthly and lead this planning. This group will be charged with writing a Sustainability and Transition Plan by the end of the first quarter for approval by the Executive Committee and discussion with EOHHS, ACOs and MCOs. As appropriate to their roles, BHCP will also inform and involve the following in sustainability and transition planning: Enrollees, staff, community partners and vendors.

I. Quality Management and Performance Monitoring

BHPMW will meet all quality management and quality improvement (QI) requirements in the Model Contract and be geared toward achieving good performance on the Quality and Accountability protocols in Appendix C through a multi-pronged QI program, QI plan, Quality Management Committee (QMC) and quality initiatives.

1. Quality Improvement Program

BHPMW BHCP's QI Program will be aimed at improving outcomes for Engaged Enrollees; addressing The Institute for Healthcare Improvement Triple Aim: 1. Improve the health of populations. 2. Reduce the per capita cost of healthcare. 3. Improve the patient experience; and positioning the BHCP to achieve positive outcomes on the individual measures and member experience survey in support of the BHCP's Quality Score and DSRIP Accountability Score.

The QI program will be comprised of:

Leadership: BHPMW leadership staff and senior staff in the CEs and AP will be committed to continuous quality improvement (CQI) and the goals of BHCP's QI program. There will be shared understanding that they must manage the program based on data and be agile to change course based on that data, the performance and outcomes they reflect, and learning from QI activities.

QI Structure: As described in J.3., the QI structure will include the QMC and the Governing Body Executive Committee, with various staff roles and responsibilities for the QI Program and Plan.

QI Plan: QI Plan will be established, submitted and approved by EOHHS annually, and maintained. It will include a systematic approach to improving processes and outcomes through the application of CQI principles and at least one specific QI initiative, which is implemented and evaluated annually, addressing at least one of the following areas: quality of life; chronic disease management; caregiver stress; community tenure; isolation and social connectedness; care coordination and care management; or care transitions.

Performance Measures: Performance measures will be based on the Model Contract requirements and aligned with the individual measures and member experience of care measures determined by MassHealth. To a great extent, the BHCP will utilize those measures as defined. Additional measures will be identified to improve processes and outcomes that support the individual and member experience survey measures. Measures will be selected based on their relevance and the frequency and depth of impact they can have; measurability within the BHCP's capabilities, resources, and access to needed data; and feasibility for the BHCP to realistically improve.

Performance Measurement: BHCP will collect the data needed to measure the identified metrics to monitor the selected aspects of the programs, systems, and processes

Performance Management: Goals will be set and progress toward achieving those goals will be checked regularly by reviewing data on the performance measures and taking action on the results to improve progress toward goals.

Plan Do Study Act (PDSA): This CQI approach will be utilized to understand the problem, target improvement, define measures, measure performance, spanning many components of the QI

program listed above. Many senior staff and others in the BHPMW, CEs and AP have been trained in PDSA and implemented this model.

Evidenced Based Practices (EBPs) and best practices: The practices that will be built into BHCP's delivery of CP supports include Motivational Interviewing, Peer Support, Shared Decision Making, Trauma Informed Care and Wraparound. Additional EBPs and best practices will be identified to address QI needs targeted in the annual quality initiatives.

Training and adoption: Staff will be trained on the EBPs and best practices. Performance standards and protocols will be established to ensure adoption and fidelity to the model.

Data Analytics: Data collection, reporting and analysis will be critical throughout many of the components of the QI Program. Advocates Data Analytics Department will lead data analytics for the BHPMW BHCP.

The Director of Population Health Management, who will also fulfill the required Quality Management Director position, will be responsible for developing, managing and implementing the QI Program, under the supervision of the Program Director, and with the approval of the Executive Director, QMC and Governing Body Executive Committee. Section J.3. details processes associated with implementing the QI program and annual quality initiatives.

2. Budget Period Initiative and Measures for Success

In Budget Period 1, BHPMW BHCP's initial quality initiative will be establishing Assigned Enrollees' timely Care Transition into the BHCP. The goal will be to optimize members' transitions from "Assigned" to "Enrolled."

To accomplish this goal, as discussed in 7.3.C.1., BHPMW will devote all resources to outreach and engagement during the first year to maximize the enrollment of as many members in BHCP as quickly as possible. The Care Coordinators (CC) and Clinical Care Managers (CCM), Peer Specialists, Recovery Coaches and Family Partners will conduct outreach and engagement activities with specific training and support from the BHCP program managers and quality managers at each CE and AP. EBPs will include peer support and motivational interviewing. BHPMW BHCP Director of Population Health will manage Enrollee assignments efficiently and train CP teams on outreach and engagement best practices. As noted in 7.3.C.2., staff will strive to complete the assessment and treatment plan within two months of initial assignment to allow one month to obtain PCP approval and submit a "Person-Centered Treatment Plan Complete" Qualifying Activity by the end of the third month.

Initial measures will include:

- the number and percent of Assigned Enrollees that become Engaged Enrollees
- the number of days from the Enrollee's assignment to the BHPMW BHCP to the Enrollee's signing of participation forms
- the number and percent of Assigned Enrollees that do not become Engaged Enrollees and the reasons for not engaging

BHCP will track this data beginning the first day of contract implementation and the data will be monitored continually by the Program Director and Director of Population Health. Data will be reviewed at the first QMC meeting during the first quarter of Budget Period 1, recognizing that data will be preliminary since the first group of Assigned Enrollees will still be in the first three month period. Data will be reported and analyzed for each CE and AP and for the entire

BHPMW BHCP. CCs, CCMs, Peer Specialists and other staff will be consulted about the strategies that are working to outreach and engage Assigned Enrollees and facilitate the care transition into the BHCP as an Engaged Enrollee. Their use of EBPs - motivational interviewing and peer support - at this stage will be assessed and other best practices identified.

3. Quality Management Committee (QMC) Composition and Functions

BHPMW BHCP will establish and maintain a QMC throughout the Contract Term. As outlined in 7.2.C., the QMC is one of three components of the BHPMW BHCP governance structure, along with the Consumer Advisory Board and the Governing Body Executive Committee. It will report to the BHCP Program Director and, through the Executive Director, to the Governing Body Executive Committee. Under the Program Director's supervision, the Director of Population Health will be responsible for organizing, planning, and convening the QMC and ensuring its responsibilities are completed and documented.

QMC membership will include: BHPMW BHCP Executive Director, Medical Director, Program Director, Director of Population Health Management; Advocates VP Data Analytics; and in each CE and AP, BHCP Quality Manager and a senior staff to whom the BHCP reports, totaling 15 members. The QMC will be responsible for developing the QI Plan and overseeing the QI Program and the PDSA CQI process. This group will meet quarterly to review data and plan and monitor QI activities.

In developing the annual QI Plan, QMC will identify at least one specific quality initiative to implement and evaluate within each Budget Period. The annual quality initiative for Budget Period 1 is specified in 7.3.J.2. In subsequent years, QMC will weigh the impact that a given process or other improvement target can have on BHCP Enrollees by considering these criteria: high volume, affecting a large number of members; high frequency; high risk, placing Enrollees at risk for poor outcomes; longstanding; multiple unsuccessful attempts to resolve in the past; strong and differing opinions on cause or resolution of the problem. QMC will review data, brainstorm opportunities for improvement, nominate and prioritize processes or outcomes to target and select the annual quality initiatives.

Another function of the QMC will be reviewing critical incidents. QMC will also oversee the use of EBPs and best practices, reviewing related data and recommending additional practices that would help to make progress toward established goals.

To facilitate the CQI process up through the reporting structure, on a quarterly basis, the Program Director will report on key findings, QI interventions and needs or barriers to the Executive Director, who will bring this information to the BHCP Governing Body Executive Committee. That group will review and approve the annual QI plan and, on an ongoing basis, give input and make decisions in response to the information from the QMC. The Program Director will also bring data from the CQI process and QMC meetings to the Consumer Advisory Board for review, input into selecting quality initiatives, and recommendations for strategies to make progress toward goals.

To extend the CQI process throughout the CEs and AP's, their senior staff and BHCP Quality Managers, who will be QMC members, will be responsible for bringing data, the PDSA CQI process and quality initiatives to their CP teams and implementing them accordingly. The Director of Population Health Management will work with the CEs and APS BHCP Quality Managers to ensure implementation of all aspects of the QI program.

J. Coordination with ACOs and MCOs

1. Communicating BHCP skills, expertise and value to potential ACOs and MCOs

Communicating BHPMW BHCP skills and demonstrating the value they will bring to the ACOs, MCOs, their primary and specialty care networks and their Engaged Enrollees will be critical to the operational success during the five year demonstration program and sustainability thereafter. BHPMW BHCP CEs and AP have relationships with numerous MCOs and payers as reflected in 7.2.D.1. A centralized approach will be utilized to communicate and outreach to the ACOs and MCOs for multiple purposes: relationship building, contracting, marketing and sustainability. BHPMW Executive Director Anne Pelletier Parker has primary responsibility for expanding relationships and managing the communication and contracting with these entities. She is well connected to the healthcare and health insurance industries in Massachusetts, particularly the MassHealth MCO and provider networks, and has expertise in care management, integrated care, program development and provider contracting in both public managed care and community-based provider settings. She will be supported by CEO/President/Executive Directors of the CEs and AP and other senior staff who have relationships with various payers and extensive experience in healthcare operations, model development, care delivery and contracting.

BHPMW has already begun leveraging these connections, meeting with multiple ACO pilots and applicants during the past year. Significant time has been spent with existing ACOs affiliated with MetroWest Medical Center and their physician groups, as many of them will be part of Fallon/Wellforce, a potential MassHealth ACO with Service Areas in the Central and North regions, consistent with those of the BHPMW BHCP. Initial contact has also been made with NEQCA leadership who will be part of Wellforce. Multiple contacts have been made with Steward Health Care and Reliant Medical Group as they have also applied to be ACOs in these Service Areas. These and other ACO contacts have focused on developing shared understanding of the general role of BHCP and the assets the BHPMW BHCP can offer: expertise in BH, LTSS, social determinants of health and many of the focus populations; integrated care management experience; community embeddedness and access to social services and community resources; a communitybased workforce that can connect with members in their homes and communities; and direct access to the CEs and AP's BH and other continuums of care.

While the development of high level relationships and contracts and formal marketing will be important, the most impactful way to demonstrate value is through the work of the CP teams with the ACOs and MCOs members, their primary and specialty medical provider networks and their internal care management programs. As described in section 7.3.C., engagement with PCPs, specialty providers, ACOs and MCOs begins prior to contract implementation and is integrated throughout BHCP's delivery of all the CP supports and activities.

2. Branding and Marketing Plans with ACOs and MCOs

With grant funding from the MetroWest Health Foundation, BHPMW has already worked with CEs marketing teams, a graphic designer, and website consultants to create a logo, design marketing sell sheets, and begin to envision a website. These tools will be used to reach out to ACOs and MCOs, Assigned and Engaged Enrollees and stakeholders who may identify members through the referral-based process. Because the BHPMW, LLC is

becoming operational in June/July 2017, offering a referral line to the greater MetroWest community, a marketing plan is already being implemented, including a kick-off event, press releases, mass mailing, and a social media strategy designed to build interest in and excitement about this new point of access to BH and other services. With this work well underway, BHPMW is strategically positioned to implement BHCP-specific marketing and communications. BHCP marketing plan will focus on increasing visibility and brand recognition and providing education with regard to this new program. BHCP print materials will be developed and stakeholder meetings and kick-off events will be held for MCOs, ACOs, PCPs, Enrollees and other stakeholders, highlighting the benefits of the BHCP in the redesigned MassHealth system. Ongoing editing of materials to meet the evolving needs of the developing program will provide an opportunity to promote best practices identified during early stages of implementation. Updated materials will highlight outcomes and cost savings that demonstrated the BHCP's value to the ACOs, MCOs and other stakeholders.

3. Engagement and Collaboration Strategies with ACOs and MCOs in Service Areas

As detailed above, BHPMW Executive Director and CEs and AP senior leaders have been actively involved in initial conversations with potential MCOs and ACOs. Attention has been paid to the ACO, MCO and CP procurements and efforts to ensure appropriate alignment of mission and goals. Partnering in a way that promotes the goal of health care integration for Enrollees with the greatest needs, promoting better outcomes in a more cost effective manner, will create the platform for collaboration with ACOs and MCOs. Applying this value proposition to multiple ACOs and MCOs in the BHCP's proposed Service Areas will require developing an understanding of each entity's membership, service delivery and care management models and clinical/quality/financial goals. BHCP Executive Director and Program Director will work with each ACO and MCO to develop a role, approach and protocols for the BHCP to be responsive to their priorities, promote integration and add value to their model. Planning for the sustainability of CP supports and related infrastructure will likely require individualized planning and solutions with each ACO and MCO.

Continued and consistent engagement with all ACOs and MCOs will include ongoing outreach, communication, responsiveness, and relationship building. As noted above, most critical to ongoing engagement will be the BHCP's outcomes related to the delivery of CP supports.

4. Conflict Resolution with ACOs and MCOs

BHPMW is committed to providing quality service that meets and exceeds all expectations of the BHCP program model; a collaborative approach to working with ACOs and MCOs; and providing excellent customer service to all stakeholders. Potential conflicts will be mitigated through comprehensive contract negotiations with explicit documentation of roles, expectations and deliverables. Ongoing communication among all parties and the use of data are essential to ensure smooth and transparent processes, promoting bidirectional adherence to established performance goals. Mutual familiarity, respect and trust that exists between the BHPMW, CEs and AP and some of the ACOs and MCOs will continue to be expanded, and will be assets in preventing and resolving conflicts that arise.

It is to be expected that conflicts will still occur from time to time. BHPMW will seek to reach a mutually agreeable solution with the ACO or MCO. The Program Director will address issues at an operational level and the Executive Director will do so at the senior level in the ACOs and MCOs. The Executive Director will utilize the BHCP governance structure outlined in 7.2.C.1.d.

for consultation and direct involvement, if needed. It is also anticipated that BHCP's contracts with ACOs and MCOs will specify conflict resolution protocols.

Monthly Implementation Plan and Timeline: Budget Preparation Period (Rev. 12/1/17)

Domain*	Task	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Budget Preparation Period : August 2017 to May 2018											
Contracting and EOHHS contract management	Learn if awarded contract										
	Enter into contract negotiations with EOHHS										
	Execute contract with EOHHS										
	Provide EOHHS with contact info of staff to represent BHPMW & maintain financial records										
	Establish quarterly meeting with EOHHS										
	Develop & submit initial DSRIP Participation Plan										
	Obtain EOHHS approval of initial DSRIP Participation Plan										
	Participate in trainings, community forums, learning collaboratives, meetings, events requested by EOHHS										
	Successfully complete EOHHS Readiness Review										
	Enter into negotiations for contractual agreements with ACOs & MCOs										
	Execute contractual agreements with ACOs & MCOs										
Reporting	Establish reporting schedule with EOHHS										
	Develop report templates & workflows for Member Status Report, Quality Measures Report, & other reports as required										
Governance Structure	Finalize BHCP governance structure including Governing Body Executive Committee membership										
	Document policies regarding conflict resolution & contract oversite										
	Execute agreements/subcontracts/BAAs with CEs & AP										

	Establish schedule & conduct Governing Body Executive Committee meetings before & throughout contract term										
Implementation and Operations	Establish BHPMW BHCP implementation team, hold orientation meetings to establish work plan										
	Implement & monitor work plans to completion										
	Establish bimonthly BHPMW contract management meetings with each CE & AP to assess & support readiness activities										
Budget, Finance and Billing	Conduct financial consultation meeting with PCG										
	Submit a Budget Report & Budget Narrative for Budget Preparation Period to EOHHS for approval by date set by EOHHS										
	Submit a Budget Report & Budget Narrative for Budget Period 1 to EOHHS for approval										
	Receive DSRIP payment for Preparation Budget Period										
	Establish systems for accounting & financial management										
	Develop & process map the system for billing, payment and remit										
	Test billing system										
	Develop system to receive care coordination PMPM payments from EOHHS & reimburse CEs & AP for CP supports										
	Develop system to monitor DSRIP infrastructure spending and related reporting										
Information Technology	Confirm capability to meet all IT requirements including supporting statutory & regulatory requirements, sending & receiving MassHealth eligibility files & electronically storing Enrollee info										
	Develop policies & procedures for info sharing, EHR/care management system use & MA HIway connection, ensuring all										

	exchanges are secure										
	Support CEs& AP in connecting to MA HI way as needed										
	Develop & maintain a care management system to document CP supports, Qualifying Activities, & Enrollee info in compliance with Model Contract										
	Develop & maintain internal systems to determine the validity & completeness of data submitted to EOHHS										
	Subscribe & connect to a statewide Event Notification System once developed by EOHHS										
	Equip staff with laptops and cell phones										
Care Management Software	Finalize care management software selection & sign letter of intent										
	Execute contract with care management software vendor										
	Establish regular meetings with care management software vendor to customize & operationalize system										
	Finalize customization of care management software including reporting capacity										
	Test care management software										
	Train staff on care management software										
Interpreter and Translation Services software and/or other solutions	Analyze availability of software solutions & live solutions for interpreter & translation services										
	Execute contract(s) for software, language line, and/or other solutions for interpreter & translation services										
	Test software, language line, and/or other solution for interpreter & translation services										
	Train staff on solutions/systems										

Quality Improvement, Data Analytics and Compliance	Formalize membership of Quality Management Committee (QMC) & establish meeting schedule										
	Finalize QI plan & submit to EOHHS by date requested										
	Establish internal systems for outcomes measurement & data analytics consistent with BHCP metrics										
	Work with Compliance Officer and legal counsel to ensure all compliance issues are addressed										
	Confirm proposed quality initiative for Budget Period 1 & organize data tracking systems & orientation for staff & QMC										
Consumer Advisory Board (CAB)	Begin early identification of potential members of the Consumer Advisory Board										
	Establish CAB meeting schedule & locations										
Policies, Procedures, Protocols and Plans	Convene Policy & Procedure Implementation Team with CEs & AP										
	Develop a conflict of interest policy; submit to EOHHS										
	Write & adopt formal Continuity of Operations Plan & submit to EOHHS upon request										
	Write grievance policy & procedures; submit to EOHHS										
	Develop protocol & materials to provide Enrollees with info on the grievance policy & procedures										
	Write Enrollee rights policy & procedures										
	Develop protocol & materials to provide Enrollees with info on the Enrollee rights policy & procedures										
	Write a protocol to track, review & report critical incidents & identify key personnel to implement & monitor protocol										
	Train staff on all policies, procedures, protocols, plans										

Community Collaboration and Coordination	Develop & maintain collaborative relationships with community based organizations & state agencies										
	Develop relationships with CBFS providers to coordinate care										
Workforce development	Convene Workforce Development Implementation Team with CEs & AP										
	Finalize recruitment, orientation, training & hiring plan										
	Finalize curriculum development & operational staff training plan including dates & locations										
	Execute recruitment plan & activities to engage and hire staff										
	Hire Program Director										
	Hire Director of Population Health Management										
	Hire all remaining staff consistent with staffing rations based on volume ramp up projections										
	Conduct centralized initial orientation & training for all on boarded staff across the CP										
	Load video of trainings to web-based learning solution for ongoing access.										
Community Partner Supports	Document policies & procedures for triage & Enrollee assignment										
	Develop protocols for outreach & engagement										
	Develop protocols for Comprehensive Assessment & Person-Centered Treatment Planning										
	Finalize Assessment tool & treatment plan for programming in care management software										
	Develop protocols for Care Coordination & Care Management										
	Develop protocols for Care Transitions										

	Develop protocols for Medication Reconciliation										
	Develop protocols for Health & Wellness Coaching										
	Identify health and wellness resources; plan programs										
	Develop protocols for Connection to Community, Social & Flexible Services including follow up to ensure Engaged Enrollees are obtaining needed services as indicated by the treatment plan										
	Develop extensive network of resources including BH, medical & social services; identify gaps in Service Areas & expand existing affiliations; utilize BHPMC databased of CE services, create other databases & ensure staff access										
	Develop protocols for recommending Flexible Services to Engaged Enrollee's ACO										
	Develop protocols for provision of CP Supports to Enrollees with BH & LTSS needs										
	Train staff on all protocols & resources.										
Community Education and Marketing	Develop brochures & other written materials for enrollees consistent with program operations in multilingual and alternative formats										
	Develop written materials for primary care & specialty medical providers consistent with program operations										
	Develop website										
Community Education and Marketing (continued)	Establish individual outreach & informational meetings for area stakeholders e.g., ACO, MCO, potential qualitative referral sources										
	Visit primary care practices to introduce the BHCP, foster relationships, develop protocols for collaborating on Care Teams, treatment plans & ongoing care coordination.										

	Outreach to Enrollees with pre-existing relationships with the CEs & AP who may be eligible for CP supports to educate about the CP program & how to enroll after contract start date										

*** A primary domain was selected for each task, recognizing that some tasks address more than one domain.**

Community Partner Program Budget Report

		SDH BH CP Consortium					
Program Revenue	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
Estimated Enrollees- Start of Period (All Enrollees)		1,000	1,000	1,000	1,000	1,000	
Estimated Enrollees - End of Period (All Enrollees)		1,000	1,000	1,000	1,000	1,000	
Estimated Enrollees - Monthly Average (excl CBFS enrollees)		836	1,000	1,000	1,000	1,000	
Estimated Enrollees - Monthly Average (CBFS enrollees only)							
Estimated Program Revenue (excl CBFS enrollees)		$ 1,053,360	$ 2,160,000	$ 2,160,000	$ 2,160,000	$ 2,160,000	$ 9,693,360
Estimated Program Revenue (CBFS enrollees only)		$ -	$ -	$ -	$ -	$ -	$ -
Total Estimated Program Revenue		**$ 1,053,360**	**$ 2,160,000**	**$ 2,160,000**	**$ 2,160,000**	**$ 2,160,000**	**$ 9,693,360**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -	$ -	$ -	$ -
Revenue for Operations		**$ 1,053,360**	**$ 2,160,000**	**$ 2,160,000**	**$ 2,160,000**	**$ 2,160,000**	**$ 9,693,360**

Program Expenses		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Salary		$ 150,822	$ 950,418	$ 1,678,167	$ 1,717,438	$ 1,768,963	$ 1,822,033	$ 8,087,841
Fringe		$ 36,197	$ 228,100	$ 402,760	$ 412,185	$ 424,551	$ 437,288	$ 1,941,081
Total Personnel Costs		$ 187,019	$ 1,178,518	$ 2,080,927	$ 2,129,623	$ 2,193,514	$ 2,259,321	$ 10,028,922
Training & Professional Development		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel		$ -	$ 6,815	$ 18,760	$ 18,760	$ 18,760	$ 18,760	$ 81,855
Equipment			$ -	$ -	$ -	$ -	$ -	$ -
Supplies		$ 170	$ 1,400	$ 2,400	$ 2,400	$ 2,400	$ 2,400	$ 11,170
Contract Services (consulting, professional)		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Software licensing			$ -	$ -	$ -	$ -	$ -	$ -
Telecommunications		$ 2,100	$ 14,700	$ 25,200	$ 25,200	$ 25,200	$ 25,200	$ 117,600
Occupancy (rent, utilities, maintenance)		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Direct Costs		$ 189,289	$ 1,201,433	$ 2,127,287	$ 2,175,983	$ 2,239,874	$ 2,305,681	$ 10,239,547
Indirect Cost/Administrative Overhead	**15.0%**	**$ 28,393**	**$ 180,215**	**$ 319,093**	**$ 326,397**	**$ 335,981**	**$ 345,852**	$ 1,535,931
TOTAL EXPENSES		$ 217,682	$ 1,381,648	$ 2,446,380	$ 2,502,380	$ 2,575,855	$ 2,651,533	$ 11,775,478
Surplus/Shortfall		*$ (217,682)*	*$ (328,288)*	*$ (286,380)*	*$ (342,380)*	*$ (415,855)*	*$ (491,533)*	*$ (2,082,118)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Program Director	$ 127,000.00	0.50	7	$ 37,042
CP Medical Director	$ 202,750.00	0.20	7	$ 23,654
LICSW	$ 55,000.00	1.00	2	$ 9,167
Program Manager	$ 65,000.00	1.00	4	$ 21,667
RN Care Manager	$ 80,000.00	6.00	0.5	$ 20,000
Care Coordinator	$ 41,000.00	23.00	0.5	$ 39,292
				$ -
				$ -
				$ -
Total Salary (Program Budget Line 1)		**31.70**		**$ 150,822.00**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 150,822.00	24%	$ 36,197
Total Fringe (Program Budget Line 2)			**$ 36,197**

Total Personnel*	**$ 187,019**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

Program Director: oversees BH CP Program, develop strategic plan to establish relationships with ACOs, MCOs and Providers, act as point of contact for MassHealth, ACOs, MCOs, and SDH Affilated Partners. Supervises Program Manager reviewing and approving key document drafts.

CP Medical Director: leads and provides strategic direction for clinical teams to implement BH CP. Will be involved in educating and engaging providers including non Consortium providers about expectations under BH CP.

LICSW: liaison with area hospitals with psychiatric units and Suffolk County jails to manage transitions of care.

Program Manager: Reports to Program Director and provides administrative support to Director and CP teams including but not limited to helping with enrollment, drafting required reports to ACOs, MCOs, & MassHealth, coordinating training, initiating payment request for fund flow to Partners., etc. Supervises Team Leads. (Note: we increased the salary of this position and level of responsibility from previous submission.)

RN Care Manager: supervise and provide support to non-clinical care coordinators, engaging with enrollees for all clinical needs.

Care Coordinator: work with enrollees, engaging them in care that advances patient centered care plan goals. Number of Care Coordinators hired by Affiliated Partners is based on volume of enrollees assigned based on established relationships--approximately 40 enrollees/care coordinator.

Row 3 - Training and Professional Development

	A	B	C	D	E	F
42	**Description of Service**	**Unit Cost (if applicable)**	**# Staff (if applicable)**	**Total Cost**		
43						
44						
45						
46			**Total Training and Professional Development**			
47			**(Program Budget Line 3)**			

Provide a description of each Training and Professional Development line item included in the table above:

Row 4 - Travel

	Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
81					$ -
82					$ -
83					$ -
84					$ -
85					$ -
86					$ -
87				**Total Mileage**	

Travel Expense Description	Cost
Total Mileage	$ -
Parking and tolls	
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ -**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

Row 5 - Equipment

Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost
Total Equipment (Program Budget Line 5)			

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Materials for training			$ 170.00
Total Supplies (Program Budget Line 6)			**$ 170.00**

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:
Cost of training materials to orient the CP teams (35-40 attendees) includes office supplies and printing.

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
		Total Software Licensing (Program Budget Line 8)	

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Cellphone service plan	60	35	$ 2,100.00

	A	B	C	D	E	F
278			**Total Telecommunications**	**$ 2,100.00**		
279			**(Program Budget Line 9)**			

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Having smartphone with secure texting @ $60 per month service plan enable the CP team members to commun icate easier when doing outreach.
Each Care Coordinator and NCM will be offered a smartphone. Care Coordinators hired by Affiliated Partners will receive smartphones and their data plan will be paid for directly by BHCHP. The number of Care Coordinators hired by Affiliated Partners is based on volume--approximately 40 enrollees/care coordinator.

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent			$ -
Utilities			$ -
Repair and Maintenance			$ -
			$ -
			$ -
		Total Occupancy (Program Budget Line 10)	

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

Row 11 - Other

Other Direct Expense Description	Cost
Total Other (Program Budget Line 11)	

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	**15.00%**	**$ 28,393.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:
15% is the provisional rate effective 7/1/2016 per the Indirect Cost Rate Agreement between Boston Health Care for the Homless Program and Dept. of Health and Human Services.

	A	B	C	D	E	F
424						
425						

Community Partner Infrastructure Budget Report

		SDH BH CP Consortium						
Infrastructure Investment Funding		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
PMPM Infrastructure Rate			$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
Engaged Enrollees			1,000	1,000	1,000	1,000	1,000	
Estimated Infrastructure Funds			$ 700,000	$ 1,032,589	$ 617,900	$ 544,840	$ 471,334	**$ 3,366,664**
At- Risk Withhold Rate				25%	44%	63%	81%	
Withhold				$ 255,006	$ 269,581	$ 340,859	$ 384,109	**$ 1,249,555**
TOTAL MAXIMUM FUNDS AVAILABLE		$ 450,000	$ 700,000	$ 777,583	$ 348,319	$ 203,981	$ 87,225	**$ 2,567,108**
Infrastructure Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology								
IT Staffing including Fringe		$ 37,459	$ 94,034	$ 166,036	$ 167,728	$ 88,075	$ 90,717	**$ 644,049**
Development Adaptation of EHR and/or Care Management System		$ 70,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000	**$ 75,000**
Technology for Service Delivery		$ 5,000	$ -	$ -	$ -	$ -	$ -	**$ 5,000**
Other Technology Expenses		$ -	$ 1,400	$ 2,400	$ 2,400	$ 2,400	$ 2,400	**$ 11,000**
Total Technology		$ 112,459	$ 96,434	$ 169,436	$ 171,128	$ 91,475	$ 94,117	**$ 735,049**
Workforce Development								
Workforce Development staffing including Fringe		$ 14,880	$ -	$ -	$ -	$ -	$ -	**$ 14,880**
Recruitment Expenses		$ 500	$ -	$ -	$ -	$ -	$ -	**$ 500**
Training Expenses		$ 1,700	$ 300	$ 600	$ 600	$ 600	$ 600	**$ 4,400**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Total Workforce Development		$ 17,080	$ 300	$ 600	$ 600	$ 600	$ 600	**$ 19,780**
Business Start Up Costs								
Office Equipment (PBP & BP1 only)		$ -	$ -					**$ -**
Office Furniture (PBP & BP1 only)		$ -	$ -					**$ -**
Ramp-up Costs (PBP BP1, BP2 and BP3 only)		$ 217,682	$ 328,288	$ 286,380	$ 342,380			**$ 1,174,730**
Total Business Start Up Costs		$ 217,682	$ 328,288	$ 286,380	$ 342,380			**$ 1,174,730**
Operational Infrastructure								
Operation Staffing including Fringe		$ 5,477	$ 76,673	$ 135,383	$ 139,445	$ 143,629	$ 147,937	**$ 648,544**
Other Operational Expenses		$ 67,000	$ 20,540	$ 16,080	$ 11,080	$ 6,080	$ 1,080	**$ 121,860**
Total Operational Infrastructure		$ 72,477	$ 97,213	$ 151,463	$ 150,525	$ 149,709	$ 149,017	**$ 770,404**
Indirect Cost/Administrative Overhead Rate	15.0%	$ 30,302	$ 29,092	$ 48,225	$ 48,338	$ 36,268	$ 36,560	**$ 228,785**
TOTAL INVESTMENTS		**$ 450,000**	**$ 551,327**	**$ 656,104**	**$ 712,971**	**$ 278,052**	**$ 280,294**	**$ 2,928,748**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Helpdesk Support	$ 50,000.00	0.5	0.5	$ 1,042
IT/Data Analyst	$ 100,000.00	0.5	7	$ 29,167
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary			$ 30,209
	Fringe rate	24.0%	Total Fringe	$ 7,250
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 37,459**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Helpdesk Support: provide day-to-day support for the CP team.(Not Analytical data support)

Data Analyst : support improvements in data platform, facilitate development of reports needed to inform program performance, works with Green River vendor (and Affiliated Partner's vendors to ensure stability of the interface among EHR, ETO.). BHCHP will fund these positions to support BHCHP and Affiliated Partners on an ad-hoc basis as needed. Funding is not allocated to Partners in any particular way.

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
SDH Partners connection to ETO platform	$ 45,000.00

	A	B
34	SDH Partners' EHR Integration	$ 25,000.00
35		
36		
37		
38		
39	**Total Development and Adaptation of EHR and Care**	
40	**Management System**	$ 70,000.00
41	**(Infrastructure Budget Line 2)**	

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

$45,000 paying Green River to connect Affiliated Partners EHR's to data platform working with AP vendors if needed to improve functionality.In addition, GR will also connect PSI and BRM ETO to data platform (all other partners' ETO are currently connected. Funding is allocated based on entity need. Most of the funding will be allocated to PSI and BRM to address their connection issues. Remainder of funding will support technical assistance for newly hired Care Coordinators.

$25,000 paying to work with Affiliated Partners' EHR vendors to support EHR integration and minimize duplicate data entries. Only BHCHP, Casa, VPI, and Bay Cove have EHRs. All work with EHR vendors to operate their EHR systems (i.e. OCHIN for BHCHP). Changes in reporting and functionality will require work for vendors to charge time for their labor. We will either pay vendors directly or work out that we will reimburse AP for invoices submitted--total not to exceed this budget line. Funding is allocated based on entity need and will support entities with EHRs. There are 5 Affiliated Partners with EHRs, and each will have $5,000 to support EHR integration.

Row 3 - Technology for Service Delivery

	Description of Expense	Cost
60	Laptops	$ 5,000.00
61		
62		
63		
64		
65		
66	**Total Technology for Service Delivery**	$ 5,000.00

	A	B	C	D	E	F	G
67	**(Infrastructure Budget Line 3)**	$ 5,000.00					
68							
69	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
70	***contract and how the costs were determined:***						
71	Purchase 5 new laptops for CP teams that can be signed out when doing outreach or shared among each other when working in						
72	the office.						
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74							
75							
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77							
78							
79							
80							
81							
82							
83							
84							
85	**Row 4 - Other Technology Expenses**						
86	**Description of Expense**	**Cost**					
87							
88							
89							
90							
91							
92							
93	**Total Other Technology Expenses**						
94	**(Infrastructure Budget Line 4)**						
95							
96	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
97	***contract and how the costs were determined:***						
98							
99							

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Recruitment Coordinator	$ 36,000.00	1	4	$ 12,000
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	1		$ 12,000
	Fringe rate	24.0%	Total Fringe	$ 2,880
			Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)	**$ 14,880**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Recruitment Coordinator: assist BHCHP and Partners to recruit and hire staff for the BH CP..

Row 6 - Recruitment Expenses

Description of Expense	Cost
Job Posting	$ 500.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 500.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:
Online job posting for the newly added positions to staff the CP teams.

Row 7 - Training Expenses

Description of Expense	Cost
Cost of venue for CP staff orientation	$ 500.00
Cost of meals for all day orientation 40 @ $30	$ 1,200.00
Total Training Expenses (Infrastructure Budget Line 7)	**$ 1,700.00**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined: One-time staff Learning Collaborative for the Behavioral Health Community Partners staff to prepare them for their respective roles and ground them in training regarding working with enrollees, and collaborating with primary care and BH providers. The training will also provide a networking opportunity upon which the foundations of collaborative Team relationships to base productive working relationships.

Row 8 - Retention Expenses

Description of Expense	Cost

	A	B	C	D	E	F	G
199							
200							
201							
202							
203							
204	**Total Retention Expenses**						
205	**(Infrastructure Budget Line 8)**						
206							
207	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms***						
208	***of the CP's contract and how the costs were determined:***						
209							
210							
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221							
222							
223	**Community Partner <u>Infrastructure</u> Budget Report - Business Start Up Costs - Prep Budget Period**						
224							
225	**Row 9 - Office Equipment**						
226	Description of Expense	Cost					
227							
228							
229							
230							

	A	B	C	D	E	F	G
231							
232							
233	**Total Office Equipment**						
234	**(Infrastructure Budget Line 9)**						
235							
236	***Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were***						
237	***determined:***						
238							
239							
240							
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247							
248							
249							
250							
251							
252	**Row 10 - Office Furniture**						
253	Description of Expense	Cost					
254							
255							
256							
257							
258							
259							
260	**Total Office Furniture**						
261	**(Infrastructure Budget Line 10)**						
262							
263	***Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were***						

determined:

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Team Lead	$ 53,000.00	2	0.5	$ 4,417.00
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	2		$ 4,417.00
	Fringe rate	24.0%	Total Fringe	$ 1,060.00
			Total Program Staffing including Fringe (Infrastructure Budget Line 12)	**$ 5,477.00**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Team Lead: This is a non-clinical position that provides operational support and population health management to Care Coordination Teams working with RN Care Managers and Care Coordinators to help identify care gaps (i.e. quality outcomes) and where patients are in the system (i.e. hospitals, shelters) to identify opportunities for engagements. Works with Program Manager to develop training curriculum and Health and Wellness programming in collaboration with BH CP director.

Row 13 - Other Operational Expenses

Description of Expense	Cost
SDH Partner Admin Support	$ 48,000.00
Legal fees	$ 3,000.00
Consultant to redesign clinic space/flow	$ 10,000.00
Translation of education materials	$ 6,000.00
Total Other Operational Expenses (Infrastructure Budget Line 13)	**$ 67,000.00**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

$48,000 (8 @ $6,000) to the Partners for adminstrative support including executive or related staff attending meetings, overseeing IT integration, etc. during the prep budget period.

$3,000 legal fee: review of documents and contracts related to CP with ACOs and Affiliated Partners.

$10,000 consultant: evaluate current workspace and workflow and propose plans for improvement to integrate BH CP program into existing workflows.

$6,000 translation of patient education materials regarding the CP program.

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**15.00%**	**$ 30,302.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined: : 15% is the provisional rate effective 7/1/2016 per the Indirect Cost Rate Agreement between Boston Health Care for the Homless Program and Dept. of Health and Human Services.

	A	B	C	D	E	F	G
356							
357							
358							
359							
360							
361							
362							

Community Partner Infrastructure Allocation Worksheet

	SDH BH CP Consortium						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 700,000	$ 777,583	$ 348,319	$ 203,981	$ 87,225	$ 2,567,108
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Victory Program	$ 11,250	$ -	$ -	$ -	$ -	$ -	$ 11,250
St. Francise House	$ 5,000	$ -	$ -	$ -	$ -	$ -	$ 5,000
Pine Street Inn	$ 5,000	$ -	$ -	$ -	$ -	$ -	$ 5,000
New England Center and Home for Veterans	$ 5,000	$ -	$ -	$ -	$ -	$ -	$ 5,000
Case Esperanza	$ 11,250	$ -	$ -	$ -	$ -	$ -	$ 11,250
Boston Rescue Mission	$ 5,000	$ -	$ -	$ -	$ -	$ -	$ 5,000
Boston Public Health Commission	$ 5,000	$ -	$ -	$ -	$ -	$ -	$ 5,000
Bay Cove Human Services	$ 11,250	$ -	$ -	$ -	$ -	$ -	$ 11,250
Boston Health Care for the Homeless Program	$ 53,709	$ 96,434	$ 169,436	$ 171,128	$ 91,475	$ 94,117	$ 676,299
Total Technology	$ 112,459	$ 96,434	$ 169,436	$ 171,128	$ 91,475	$ 94,117	$ 735,049
Workforce Development							
Victory Program	$ -	$ -	$ -	$ -	$ -	$ -	$ -
St. Francise House	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pine Street Inn	$ -	$ -	$ -	$ -	$ -	$ -	$ -
New England Center and Home for Veterans	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Case Esperanza	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Boston Rescue Mission	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Boston Public Health Commission	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bay Cove Human Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Boston Health Care for the Homeless Program	$ 17,080	$ 300	$ 600	$ 600	$ 600	$ 600	$ 19,780
Total Workforce Development	$ 17,080	$ 300	$ 600	$ 600	$ 600	$ 600	$ 19,780
Business Start Up Costs							
Victory Program	$ 2,179	$ -	$ -	$ -	$ -	$ -	$ 2,179
St. Francise House	$ 4,358	$ -	$ -	$ -	$ -	$ -	$ 4,358
Pine Street Inn	$ 4,358	$ -	$ -	$ -	$ -	$ -	$ 4,358
New England Center and Home for Veterans	$ 2,179	$ -	$ -	$ -	$ -	$ -	$ 2,179
Case Esperanza	$ 2,179	$ -	$ -	$ -	$ -	$ -	$ 2,179
Boston Rescue Mission	$ 2,179	$ -	$ -	$ -	$ -	$ -	$ 2,179
Boston Public Health Commission	$ 4,358	$ -	$ -	$ -	$ -	$ -	$ 4,358
Bay Cove Human Services	$ 4,358	$ -	$ -	$ -	$ -	$ -	$ 4,358
Boston Health Care for the Homeless Program	$ 191,534	$ 328,288	$ 286,380	$ 342,380	$ -	$ -	$ 1,148,582
Business Start Up Costs	$ 217,682	$ 328,288	$ 286,380	$ 342,380	$ -	$ -	$ 1,174,730
Operational Infrastructure							
Victory Program	$ 6,000	$ -	$ -	$ -	$ -	$ -	$ 6,000
St. Francise House	$ 6,000	$ -	$ -	$ -	$ -	$ -	$ 6,000
Pine Street Inn	$ 6,000	$ -	$ -	$ -	$ -	$ -	$ 6,000
New England Center and Home for Veterans	$ 6,000	$ -	$ -	$ -	$ -	$ -	$ 6,000
Case Esperanza	$ 6,000	$ -	$ -	$ -	$ -	$ -	$ 6,000
Boston Rescue Mission	$ 6,000	$ -	$ -	$ -	$ -	$ -	$ 6,000
Boston Public Health Commission	$ 6,000	$ -	$ -	$ -	$ -	$ -	$ 6,000
Bay Cove Human Services	$ 6,000	$ -	$ -	$ -	$ -	$ -	$ 6,000
Boston Health Care for the Homeless Program	$ 24,477	$ 97,213	$ 151,463	$ 150,525	$ 149,709	$ 149,017	$ 722,404
Operational Infrastructure	$ 72,477	$ 97,213	$ 151,463	$ 150,525	$ 149,709	$ 149,017	$ 770,404
TOTAL INVESTMENTS	$ 419,698	$ 522,235	$ 607,879	$ 664,633	$ 241,784	$ 243,734	$ 2,699,963

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Development and Adaptation of E.H.R/Care Management System	Integrate EHRs and CM software into shared data platform to support communication among BH CP including real-time notifications of ADT and other signficant events to Care Coordination teams.	11/01/17	12/31/18	Integration of Partner EHRs into data platform pulling problem list, upcoming appointments, service utilization, etc. on timely basis. Add number of Partners. Needs clarity. What exactly is the integration?	Partner's data feeds visible in Boston DND Platform developed for SDH Consortium.			Progress toward integrating real-time ADT feeds into data platform.	ACOs begin sharing ADT feeds with BHCHP through Epic.		
Technology												
Technology												
Technology												
Workforce Development	Training Expenses	Develop Training Curriculum including 1 day orientation and ongoing learning activities to support BH CP in understanding and meeting BH CP goals and expectations.	01/02/18	12/31/22	Draft agenda developed for May 2018 1-day orientation and training. Needs to be more robust. A somewhat draft agenda is already in PP.	Draft agenda. Please revise			One day Training completed. Learning needs for future trainings identified.	Attendance list at training. Final agenda. Evaluation summary of meeting.		
Workforce Development	Recruitment Expenses	Develop workforce capacity to enroll and coordinate care for 1000 enrollees.	02/01/18	07/01/18	Job postings listed. Recruitment staff development and launch of hiring strategy. Please provide number of job postings, number of sites. What would concretely signify hiring strategy?	Job postings. Please revise			All staff hired per proposed staffing model.	Report on FTEs hired by BH CP director.		
Workforce Development												
Workforce Development												
Business Start Up Costs	Workforce Development Staffing including Fringe	Planning for launch of BH CP including agreements with psychiatric inpatient facilities for LICSW to round; communication with ACOs around data flow; education of BHCHP and external providers for buy in to BH CP models. Etc.	11/01/17	12/31/18	Agreements with psychiatric facilities about LICSW rounding; meetings with providers; ACO agreements. How many agreements and how many psych facilities. Meeting with how many providers and how many ACO agreements?	Contracts, MOUs, meeting minutes. Please revise			Same as 3/31/18	Contracts, MOUs, meeting minutes.		
Business Start Up Costs												
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Technology for Service Delivery	Cell phones for care coordination staff; laptops to share. Please revise. This is more of a milestone/evidence instead of a goal. Goal can be operational readiness with tech tools.	05/31/18	09/01/18	n/a	n/a			Cell phones and laptops purchased and distributed.	bill of sales		
Operational Infrastructure												
Operational Infrastructure												
Operational Infrastructure												

BH Community Partner - Staffing Model

SDH BH CP Consortium

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	1000	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	0.5	*Total management oversight of BH CP*
3	Medical Director	0.2	*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs		
5	Clinical Care Managers (RN)	6	*Do not include FTEs listed in line 4*
6	Clinical Care Managers (LPHA)		*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders	2	*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff	1	*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	23	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)		*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists		
12	Program Manager	1	Provides administrative support to Director and CP teams
13			
14			
	Total FTE	33.7	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1:166	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	1:4	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff: Clinical Care Managers

7.3.A. Executive Summary

People with serious mental illness (SMI) die on average 25 years earlier than the general population.[1] For a person with mental illness and/or substance use disorders, adding homelessness further increases the disparities in life expectancy as well as the challenges in coordinating and providing care. A 2013 study of 6,500 BHCHP homeless patients demonstrated that more than two thirds had some form of mental illness, 60% had SUD, and 48% had co-occurring mental illness and SUD.[2] The study population also had high health care expenditures—$2036 per member per month compared with $568 per month for all MassHealth members. Even among this population with higher than average costs, there was a subgroup of 650 individuals, representing 10% of the study population that accounted for a staggering $71.4 million in Medicaid expenditures, mostly a result of hospital and emergency department utilization, representing 40% and 11% of the costs respectively.

Engaging complex, homeless populations in mental health, substance use, and primary care services requires strategies that exceed the capacity of traditional primary care, behavioral health, or managed care organizations to deliver. Effectively caring for and engaging this population begins with a trusting relationship that takes patience to cultivate and must be offered with dignity and respect. It requires a person-centered approach understanding that meeting basic survival needs such as shelter, safety, clothing, and food is a bridge to engagement in needed behavioral health and medical care services. In addition, engagement and care must be designed to meet homeless individuals where they are—literally, in shelters or under bridges; and figuratively, using harm reduction to begin engagement on substance use treatment.

The organizations that form the SDH BH CP Consortium have more than 250 collective years of caring for Boston's most vulnerable populations that a significant breadth of homeless individuals. Having a BH CP with the experience, trust, resources, and mission to address the extraordinary needs of this complex population will be a powerful asset for ACOs or MCOs to advance MassHealth Triple Aim goals. Through our HPC HCII SDH Coordinated Care Hub for Homeless Adults pilot (referred to after as HPC HCII pilot), we have built the foundation for cross-sector coordination and communication that spans the continuum of care across our proposed Affiliated Partners and major hospital partners. This innovative pilot leverages existing trusted relationships from established community-based providers that targets homeless, high risk/high costs MassHealth patients (all who would meet BH CP criteria). Our goals are to reduce emergency department use and hospital admissions by 20% *and* improve patient self-sufficiency by facilitating access to primary care, mental health, substance use, housing and social services. We also focus on transitions of care, connecting patients to follow-up care (medical, SUD and mental health services) post hospitalization. This pilot was purposefully designed to become a BH CP serving MassHealth enrollees in Boston. The protocols and workflows used in the pilot have been developed by our SDH Consortium partners, reviewed by our pilot Consumer Advisory Board (CAB) and tested by our pilot staff with the purpose of using our lessons learned to strengthen our BH CP capacity.

There is a critical mass of homeless individuals in the Boston-Prime Service Area that are likely to qualify for BH CP services that justifies the need for a BH CP that understand their complex needs. By integrating EHR and MassHealth PCPR claims data to estimate the percentage of PCC plan patients attributed to BHCHP who would meet draft BH CP eligibility criteria, we found that 41% would likely be eligible. Extrapolating that 41% figure to our MCO patients we found that more than 900 MassHealth enrollees (in PCC and MCO plans) would likely meet BH CP

[1]National Association of State Mental Health Program Directors Medical Directors Council, author. Morbidity and Mortality in People with Serious Mental Illness. 2006. [October 1, 2012]. www.nasmhpd.org.

[2] Bharel, M., et al., *Health care utilization patterns of homeless individuals in Boston: preparing for Medicaid expansion under the Affordable Care Act.* Am J Public Health, 2013. **103 Suppl 2**: p. S311-7.

criteria—and this is just a fraction of the demand. In 2016, BHCHP cared for more than *8800 MassHealth enrollees experiencing homelessness that were attributed to other (mostly) Boston providers.* No doubt a significant percentage of these non-attributed enrollees would meet BH CP criteria bringing a potential BH CP population in excess of one or more thousands in the Boston-Prime service area that we would contract for BH CP services. We have a BH CP ready to coordinate care for thousands of homeless and other MassHealth enrollees in the Boston-Primary service area in 2018 that will spring off core infrastructure and staff already in place by our HPC HCII Pilot.

Nov. 17-Year 1 launch. ▪We will transition from HPC HCII pilot to BH CP and transition many existing pilot Administrative staff for BH CP planning including the BH CP Director, Medical Director, and IT/Data Analyst. Senior staff will engage with ACOs, MCOs, & external providers including hospitals with psychiatric units & LTSS. ▪We will modify existing pilot legal agreements, data platform, training curriculum, assessments, and integrated care plan as needed for BH CP. ▪We will contract with IT vendor to connect Affiliated Partners' EHRs to our data platform and expand the capacity of our cloud base server. ▪Monthly Consortium will continue and bimonthly Consumer Advisory Board (CAB) meetings will be relaunched with plans to conduct a needs assessment for 'health promotion' programs & other community activities.

Year 1: ▪With the Program Manager will work with Team Leads to orchestrate outreach and enrollment in the BH CP program leveraging the data platform to locate enrollees and communicate between team members. ▪Using needs assessment data, Program Manager and Team Leads will work with Affiliated Partners & BH CP NCMs to develop and implement activities to engage enrollees. ▪BH CP Care Coordination Team will meet face-to-face with enrollees for ongoing engagement and connection to needed services, case conferencing, care transitions. BH CP will document all encounters, monitor data, and conduct performance PDSA cycles.

Year 2-4: Scale BH CP beyond 1000 to accommodate more enrollees; add BH CP team staff. ▪BH CP activities as above, conduct bimonthly trainings ▪Update community needs assessment ▪Assess whether some staff roles can be consolidated to adapt to declining DSRIP revenue.

Year 5: ▪BH CP activities as above. ▪Negotiate with ACOs and MCOs for new contract cycle.

7.3.B Supporting Populations and Community Engagement

Our SDH BH CP Consortium will be an expert partner in helping MassHealth PCC, ACOs, and MCOs to improve the delivery of care to Boston's homeless and other enrollees with SMI, SUD, and medical complexity--no doubt the highest cost, highest needs MassHealth enrollees. Our model of providing 'intensive care coordination' focused on homeless Medicaid enrollees is similar in vision to Minnesota's Hennepin Health's "Ambulatory ICU." This initiative also focuses services on a high concentration of Medicaid homeless enrollees and was found to be a key strategy to the ACO's success in achieving savings greater than $24,000 per patient/year.[3]

Our SDH BH CP Consortium will pool together the best expertise for delivering the spectrum of services across 9 long-standing, community-based organizations in Boston; innovative data infrastructure (with legal agreements already in place enabling sharing physical, behavioral, social service data as well as housing data from the City of Boston) for integrated care coordination **and** performance feedback at the enrollee, care coordinator, site, and system level; and the biggest footprint to find and engage homeless enrollees face-to-face. BH CP Care coordinators will be based in the community where homeless people go: the street, day shelters,

[3]Bodenheimer, T. Strategies to Reduce Costs and Improve Care for High-Utilizing Medicaid Patients: Reflections on Pioneering Programs. Center for Health Care Strategies, Inc. October 2013

night shelters, temporary and permanent housing, primary care clinics, mental health centers, substance use treatment facilities, etc.

The Bidder and Affiliated Partners represent 9 community-based organizations that span the continuum of care: primary care, substance use treatment, mental health, social services, and housing and shelter providers. We are actively engaged with an advocacy organization in our BH CP planning: Massachusetts Housing and Shelter Alliance (MHSA) who continues to be a voting member in our SDH Consortium and part of our OHCA agreement (see 7.2.C). The SDH Consortium that includes the 9 organizations named on this proposal and MHSA have been convening since 2013 to improve cross-sector collaboration and service delivery of homeless services and work toward becoming a MassHealth CP.

With MassHealth approval, our BH CP will identify new resources to connect enrollees to needed services identified in their Patient Centered Treatment Plan by their BH CP team. We will formalize relationships with LTSS organizations that we have had successful relationships with in our OneCare work that have been responsive to our patients' needs. We will expand our work with community based organizations to conduct Health and Wellness Fairs offering yoga, nutrition classes, and opportunities to get wellness and prevention care visits. We will collaborate with area hospitals that have psychiatric units —something we have longed desired to do, but have not had the resources-- to coordinate discharge transitions.

We will keep our BH CP staff informed of new resources through bimonthly e-newsletters and trainings. Our SDH Consortium continues to meet monthly and will continue to be a major source of communication for information exchange and sharing of best practices, new resources, MassHealth updates, etc. Meeting minutes are taken and circulated widely between Consortium members to keep staff updated. These meetings will continue as our governance model for our BH CP.

Section 7.3.C Community Partner Supports and Activities

BHCHP and its Affiliated Partners are expert at caring for vulnerable populations, especially homeless individuals. Homeless individuals with serious mental illnesses, substance use disorders, and medical complexities require expert support navigating a complex system that spans the continuum of care. These individuals often have multiple overlapping providers and case managers and rarely one point person or team that understands the whole picture including the realities homeless individuals face navigating daily survival skills while struggling with mental illness, SUD, and complex medical diseases. Homeless individuals get lost in this vast system and most providers don't know where to find them or exactly how to help them without duplicating services that are already in place.

The SDH BH CP Consortium will harness the expertise and capacity of the most established and respected homeless service providers in the Boston Prime Service Area to deliver a model of care that is arguably the most innovative, comprehensive, and efficient in the nation. We propose to do so by leveraging--not duplicating-- the significant infrastructure already in place. We will evolve this infrastructure to the next level by strategically using funding from BH CP and hiring staff and making investments that will connect—not replace-- existing infrastructure.

BHCHP--with primary care sites (many of them offering integrated behavioral health care) in more than 40 locations, a multidisciplinary street team, and imbedded staff at major hospital systems--has a significant footprint in Boston. Adding our Affiliated Partners to this footprint with staff that serve homeless and unstably housed individuals at day and night shelters; temporary and supportive housing units, addiction treatment centers; mental health clinics; day programs, etc. means that we are in most places where most homeless individuals go. The experienced, effective, compassionate staff from BHCHP and Affiliated Partners will work in

close collaboration and approximation with the BH CP Teams. The Care Coordinators staff hired by our Affiliated Partners will be based locally enabling collaborative and coordinated efforts to find, outreach, engage, and support enrollees with serious mentally illness, SUD, and chronic medical illnesses.

1. Outreach and Active Engagement

Outreach and engagement for enrollees especially those experiencing homelessness is, no doubt, the most challenging required activities; but it is precisely the task that demonstrates why our BH CP will be an asset for MassHealth, ACOs, MCOs, and PCPs and BH providers. Our SDH BH CP Consortium with longstanding, functional cross-sector relationships will be able to outperform any other BH CP in outreach and engagement with face to face encounters especially with homeless enrollees augmented by enhanced communication.

The unique capacity of our proposed SDH BH CP Consortium will be enabled by an Organized Health Care Arrangement (OHCA) in place since December 2016 that allows us to communicate PHI, housing, social service, and other data. The OHCA allowed the development and launch of a shared data platform—a cornerstone of our HPC HCII pilot. The data platform connects the Consortium through sharing real time data including team notes to administrators, clinicians, and case managers to support outreach and enrollment efforts. It was designed to be scaled for the MassHealth BH CP program. Our shared data platform will enable our BH CP teams to identify locations where homeless patients are sleeping and accessing services, so that we can find them, discuss the BH CP program face-to-face, and gain their participation into the program (and, of course, engage them in care--more on this later.) No other MassHealth BH CP will have this intelligence to conduct a robust outreach and active engagement for this hard to find enrollee population. Other BH CPs will fail if they rely on telephonic encounters with homeless enrollees. Telephonic encounters are an unreliable way of communicating with homeless individuals who often do not have phones, run out of minutes, or change their numbers frequently. Our SDH BH CP Consortium will be able to leverage the data base to support face-to-face visits by knowing where to find enrollees.

The data platform enables us to conduct:

1. Face-to-face outreach where homeless individuals sleep. The HPC HCII pilot data platform pulls daily HMIS data (enabled by a BAA with the City of Boston) that provides shelter/housing census data to help our Consortium case managers find, discuss the pilot benefits, and ultimately gain their consent into the pilot. This capability will be an asset for our BH CP and means that we can track enrollees in all or most of the Boston shelters, day programs, and streets, helping our BH CP teams locate hard-to-find enrollees and go to the appropriate shelter or temporary/permanent housing for a face-to-face encounter.

2. Face-to-face outreach to where homeless individuals access services. In our HPC HCII pilot, BHCHP's Epic EHR and BHCHP RNs embedded at BMC, MGH, Tufts, and BHCHP Respite facilities facilitate access to real-time Admission, Discharge, and Transfer (ADT) data. (Note: with BH CP funds, we plan to embed an LICSW to manage care transitions at area hospitals that have psychiatric units as well as spend 20% of his/her time managing transitions at the Suffolk County Jails). This data is critical for outreach purposes. It allows us to find, outreach, and enroll target patients face-to-face while they are currently an inpatient and discuss the pilot program and ask, "Would you like to work with us in helping you stay out of the hospital?" Patients are vulnerable while in the hospital and are often found to be more open to accepting help from intensive case management/care coordination initiatives.[4] [5] We will use our lessons learned from

[4] Sandberg, S.F., et al. Hennepin Health: a safety-net accountable care organization for the expanded Medicaid population. Health Aff (Millwood), 2014. 33(11): p. 1975-84.

this strategy to find, outreach, and discuss the BH CP program face-to-face and gain participation with identified enrollees.

In addition, our HPC HCII Data Platform gives us the ability to identify when and where our target patients have existing appointments with BHCHP primary care and behavioral health providers so that we can outreach and enroll patients face-to-face while they are in waiting rooms. This data is refreshed daily using BHCHP's EHR. If we are selected to be a BH CP, we will use ICB grant funding and add our Affiliated Partners' EHRs to the data platform to enhance our ability to view scheduled appointments with our Affiliated Partners to augment outreach efforts. For those enrollees that access care from providers external to our SDH BH CP Consortium, our Epic EHR is able to access appointment information from providers that also use Epic. This feature will provide another important data source for outreach for a significant percentage of homeless enrollees.

Our decentralized BH CP Care Coordination Teams (NCM and Care Coordinator) coupled with the immense combined footprint offers many advantages: 1) It give us a leg up finding, outreaching, and gaining signed participation forms from the assigned BH CP enrollees face-to-face. This effort will involve both BH CP and existing BHCHP and Affiliated Partner staff. 2) Since the BH Care Coordination Teams are conducting a vast majority of the outreach including obtaining signed participation forms face-to-face, we will be able to accelerate the process of completing the Comprehensive Assessment and scheduling a Case Conference because the connection between the enrollee and BH CP Care Coordination Team has been established. The BH CP Care Coordination Team may be able to conduct the Comprehensive Assessment at the same time of gaining the participation form and schedule a case conference. (We are testing this workflow/protocol in our HPC HCII grant and are planning to adapt this process for the BH CP program).

Our protocol for outreaching and engaging enrollees begins during the Start-up/Preparation Period where we will establish BH CP Care Coordination Homes. BHCHP BH CP Director, CMO, CMO, and Affiliated Partners Senior Leadership will review the list of identified MassHealth enrollees and run this data against Consortium partners' internal EHRs and service records to identify robust, recent relationships with each enrollee and designate an organization that is best positioned to be the BH CP Care Coordination Home. (Note: As mentioned in other sections, the significance of building on existing, established relationships cannot be overstated. It will provide the best possible advantage for basing a BH CP relationship with a population that often can take long periods of time to build trust.) *This means we will have effectively assigned a BH CP Care Coordination Team (NCM and Care Coordinator) before we launch on June 1, 2018.*

For those enrollees without robust relationships to any one of us, we will adapt the protocol developed for our HPC HCII pilot. In these instances, we will determine an assignment of a BH CP Care Coordination team based on other factors such as veteran status; language preference; and organizational capacity. Having this process established pre-launch will enable us to mobilize assigned teams to quickly outreach and engage enrollees to consent to participate in our SDH BH CP Consortium when we move to launch.

On April 2, 2018 BH CP Director will convene our SDH Consortium to verify BH CP Care Coordination 'Home' assignments agreed to in Start-up/Preparation period. This data will be entered into the data platform signaling to the BH CP Care Coordination Teams to begin outreach.

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[5]Camden Coalition of Healthcare Providers. 2016 [cited 2016 May 9]; Available from: https://www.camdenhealth.org/.

As new MassHealth enrollees get added to our BH CP, the BH CP director will share identified enrollees in real time with our Consortium partners via secure email. Each organization will run the names against their internal data to identify where enrollees have been accessing services and respond within 48 hours. The BH CP Director will then assign a BH CP Care Coordination Team within 48 hours of entering the data into the platform which will signal to the designated team to conduct outreach to the enrollee to gain their participation in the program.

Within the first month of receiving the identified enrollee from MassHealth we will attempt Outreach and Enrollment into the BH CP program. Based on our HPC HCII pilot model we will scale our current 4-prong outreach and enrollment strategy. If unsuccessful in the first attempt, we will repeat the process at least monthly, knowing that consent to participate is often gained after several attempts.

1. If a potential enrollee is an inpatient: BHCHP RN embedded at hospitals or respite facilities and LICSW based at hospitals with psychiatric units will check daily census/ADT data and meet with a potential BH CP enrollee face-to-face. The embedded BHCHP staff will review BH CP program (using script that reviews the design, purpose, and benefits of the program; how PHI will be shared among SDH BH CP Consortium for the purpose of coordinating care; identify who should be on the BH CP team and how to engage with them; opportunities for opting out of the BH CP program; and options to request assignment to a different "Care Coordination Home" within our Consortium or different BH CP altogether); and consent enrollee. Staff will upload the participation form into Data Platform, which will signal to Care Coordination Team to begin engagement. Program Manager will notify ACO/MCO and MassHealth.

2. If a potential enrollee has an appointment at one of our Consortium's BH or Primary Care clinics: Assigned BH CP Care Coordination team will outreach face-to-face (using script described previously) and consent before or after provider appointment. If appropriate, BH CP Care Coordination Team (NCM or Care Coordinator) will speak to BH CP Team (PCP, BH clinician, etc.) to see if they would be able to discuss and consent potential enrollee (using script) during the appointment. BH CP Team will upload participation form into Data Platform. Program Manager will notify ACO/MCO and MassHealth.

3. *If a potential enrollee is accessing day/evening shelter services or temporary/permanent housing*: Assigned BH CP Care Coordination team will use HMIS data and identify where a identified enrollee is residing. A member from the BH CP Care Coordination will outreach face-to-face and enroll patient (using script) or contact Affiliated Partner shelter/housing staff to determine if they can approach and gain participation face-to-face (using script). Staff will upload participation form into Data Platform. Program Manager will notify ACO/MCO and MassHealth.

4. *If a potential enrollee is sleeping on the street:* Both BHCHP and PSI have experienced and collaborative Street Teams. This outreach and engagement occurs both through daytime and nighttime (9p – 5a) rounds and will allow for face-to-face engagement. The Street Team Care Coordination team will outreach and enroll patient (using script) and upload participation form into Data Platform. Program Manager will notify ACO/MCO and MassHealth.

2. Comprehensive Assessment and Person-Centered Treatment Planning

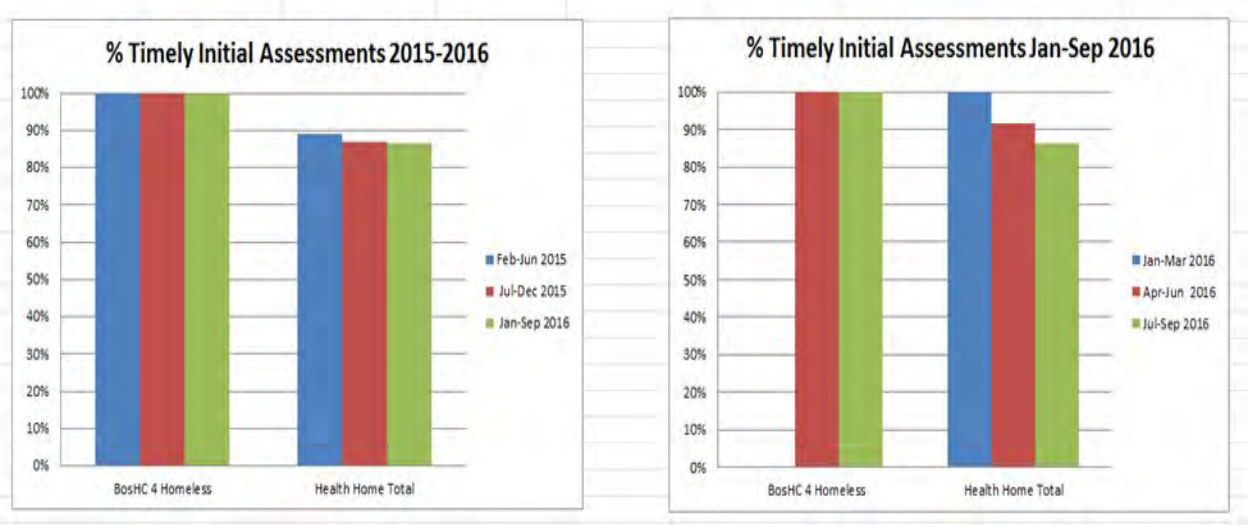
The SDH BH CP Consortium will build from the foundation we established from our HPC HCII pilot, adapting workflows, protocols and assessments in use by the pilot to meet the requirements of MassHealth BH CP program. During the face-to-face consent process for the MassHealth BH CP program, either the staff person gaining consent will share with enrollee the Consortium partner that has been designated as the BH CP "Care Coordination Home'. If the enrollee would like to change to another Consortium partner, we will do so. The staff person will upload the

participation form in the data platform. This process will result in an electronic notification sent to the BH CP Care Coordination Team (NCM and Care Coordinator) that the enrollee has consented for care. From this point, like our HPC HCII pilot, the BH CP Care Coordination Team will have 3 business days to contact the enrollee to set up a face-to-face time for a comprehensive intake assessment.

As mentioned, contacting a homeless enrollee by phone can be challenging. In our HPC HCII pilot and Commonwealth Care Alliance (CCA) One Care contract, after a patient has consented for care, we are able to offer them a cell phone and pay for their monthly bills if they indicate that they do not have a phone and are willing to engage in care. Both the One Care (launched May 2017) and HPC HCII (scheduled: July 2017) cell phone pilots were a result of BHCHP's advocacy on behalf of our patients to offer cell phones as a tool to better engage and communicate with populations that were identified for complex care management. If these strategies prove successful, we will work with the ACOs and MCOs to use flexible support funding to help pay for phones and/or minutes for a certain subset of our BH CP enrollees.

"Catching" an enrollee to conduct a comprehensive assessment before or after an enrollee shows up for a scheduled provider appointment is another strategy that we will scale in our BH CP program. This and other outreach strategies for our One Care patients has resulted in BHCHP having the highest timely "Initial Assessment" metrics among *all Health Homes* in our One Care contract for 2015-2016. (See graph below). This includes outreach time to schedule an assessment, an in-person encounter to complete the MDS (initial assessment), and a care plan entered into CCA's EMR no later than 80 days after enrollment. *BHCHP was more successful in engaging and completing an assessment for homeless populations than other Health Homes providers were for housed populations!*

Timely completion of Comprehensive Initial Assessments [Data from CCA]



Comprehensive Assessment. The BH CP Comprehensive Assessment will be adapted from our HPC HCII pilot intake process. In our pilot, the first view into the data platform is a data dashboard that aggregates data from multiple sources and gives users the ability to see to drill down for more comprehensive detailed data if needed. Our BH CP Comprehensive Assessment will expand on this work adding data from our SDH BH CP Consortium Partners' EHRs and assessments.

There are several advantages to our proposed approach to aggregate data from several sources to form the BH CP Comprehensive Assessment. 1) We have found questions from many standard assessments (e.g. the MDS for One Care) are simply not practical or relevant for homeless patients. 2) Data from standard assessments are not available or aggregated in a useful or timely way for the integrated care team to take action. 3) We can reduce burden on the enrollee who is frequently the subject of multiple assessments from multiple programs. 4) We can reduce burden on the Care Coordination Team (NCM and Care Coordinator) on double data entries and free up time for care delivery. The sources of data for the BH CP Comprehensive Assessment and workflows are:

1) Homeless Management Information System (HMIS) data assessment (See attachment 1). The Care Coordinator will conduct the initial assessment during the first 3 months after enrollee assignment to our BH CP by using the HMIS intake assessment. ▪We are using the HMIS as one of our assessments for the HPC HCII pilot in a unique partnership the City of Boston in its Continuum of Care efforts to end chronic homelessness. Through a BAA with the City, we pull HMIS data into our pilot data platform to inform interventions to reach our pilot goals (reduce ED and hospital utilization) and to support the City's goals (reduce chronic homelessness). This collaboration is likely a nation first -- integrating housing, social service data with medical and behavioral health data in a cross-sector effort to coordinate efforts for individuals experiencing homelessness. For the BH CP we see it offering enormous value as well. ▪Case managers across sectors working with individuals experiencing homelessness already use the HMIS assessment. ▪In addition to rich demographic and housing needs data, the HMIS assessment provides a comprehensive scan of service needs including medical, mental health, and substance abuse; physical and developmental disability history; domestic violence risk; income & financial support; food & benefit programs; education, training, & language services.

2) Arizona Self Sufficiency Matrix (ASSM) (See attachment 2). During this initial intake process, the Care Coordinators will also assess an enrollee's reported self-functioning during a face-to-face meeting within the first 3 months of enrollee assignment using the ASSM—we are also using this tool in our HPC HCII pilot. This tool is well-respected and widely used for homeless populations.[6] It gives immediate feedback via a score across 20 domains (including Substance Use, Mental Health, Safety, Suicidal Risk, Life Skills & ADLs, Family & Social Relationships, etc.). The score gives us the capability to track progress on our care interventions. The BH CP Care Coordinator will upload these forms into our shared data platform that will pull the relevant data into the Person Centered Care Plan (see next section). The completed form can also be accessed by users. This assessment will be updated every 6 months to track progress toward improving enrollee's function and life.

3) EHR data. The BH CP Nurse Care Manager will ensure that the Comprehensive Assessment is complete by first 3 months of the enrollee's assignment, supplementing the Comprehensive Assessment with additional data from the EHR that will be automatically collected and entered it into the platform dashboard and Person Centered Care Plan. EHR data automatically collected will include current and past physical health, mental health, and substance use problem list; current medication list, upcoming appointments, relevant acute care plans for medical and behavioral health conditions. (Note: BHCHP EHR is currently linked to data platform, but we will use DSRIP funds to expand this capacity to our Affiliated Partners). As described in Section 7.2.E, our Epic EHR is connected to many external providers which will facilitate gathering this data from providers external to our BH CP.

[6] Culhane DP, Parker, W.D., Poppe, B., Gross, K.S., Sykes, E. Accountability, Cost-Effectiveness, and Program Performance: Progress Since 1998. National Symposium on Homelessness Research 2007.

4) Claims data. If needed, the NCM will access claims data available from MassHealth, ACOs, and MCOs to identify key members of the enrollee' BH CP Team (PCP, behavioral health clinician, specialists, LTSS provider, other relevant providers) and enter data into the Person Centered Care Plan. During the case conference (described below), the NCM will verify the core Care Team providers with the enrollee including identifying other case managers from DMH or DDS and then enter their names and contact information into the Person-Centered Care Plan (described below).

Person-Centered Care Plan. The BH CP Care Coordination Team (NCM and Care Coordinator) will schedule a case conference to meet face-to-face ideally with key members of the enrollee's BH CP Team including the PCP, BH clinician, the enrollee (and family or significant others, if willing), and others, to complete and approve the Person Centered Treatment Plan and review and update the Comprehensive Assessment within the first 3 months of an enrollee's assignment to our BH CP. The BH CP Care Coordinator will accompany the enrollee to the case conference. If the enrollee expresses strong preference not to meet in person, the BH CP Care Coordinator will meet with the enrollee prior to the case conference to discuss the enrollee's goals and priorities and share the information during the meeting. Case Conferences will also serve as an opportunity to discuss Advance Directives, provide information on options to access LTSS programs (if applicable) and other support services, identify key supports for the enrollee, self-management goals, etc.

We are excited to be piloting an integrated care plan (ICP) (see attachment 3) in our HPC HCII pilot that we think will serve as a pro-type for the Person-Centered Care Plan. The ICP is housed in the data platform and can be viewed or edited by any team member (case manager, BH clinician, PCP, etc.). The ICP includes 4-5 high priority interventions: two include housing and "other social needs", and the others draw from physical health, substance use or mental health goals. There is also a tab for a self-management goal that the patient chooses including the action steps to achieve this goal. After goals are met, they can be archived (and accessed) and new ones selected. We propose to take the lessons learned from this ICP to develop the Patient Centered Care Plan. The Patient Centered Care Plan will be approved by the enrollee and the PCP during the case conference, and updated every 6 months (like we are doing for the HPC HCII pilot). We will be able to print a copy for the enrollee to keep, translating as necessary, or provide a copy in an alternative method if he/she is interested although having a safe place to store this record is a concern for a homeless individual and we will discuss this to safeguard the enrollee's privacy.

For the BH CP, any updates to the Person Centered Care Plan will result in an electronic notification to the PCP, BH Clinician (if they are internal to the Consortium) as well as the BH CP Care Coordination Team (NCM and Care Coordinator). If the PCP and BH clinicians are external providers, it will be the BH CP NCM's role to communicate and receive their input via secure email and then download the final copy to share back with the providers.

3. Care Coordination and Care Management

A defining feature of our BH CP will be our timely face to face encounters and shared integrated data platform – both features of our HPC HCII pilot. This data platform currently supports "timely encounters" as well as enhanced communication between our BH CP and BHCHP's PCMH teams (includes integrated primary care and behavioral health providers) using care management software, Efforts to Outcomes (ETO®). The ETO software was provided to all Consortium members by City of Boston; as a result, we have capacity to share care management data on a daily basis among our medical, behavioral health, housing, shelter social service organizations to better coordinate care and reduce case management redundancy. We are able to share relevant patient medical and behavioral health data from BHCHP's EHR, track patient care including referrals to LTSS providers and social service organizations, as well as monitor performance outcomes. In short, for the first time ever, individual care is communicated across

this vast continuum of service providers. We will leverage this capacity as a BH CP to provide an extraordinary edge to coordinating care for homeless enrollees. Our current data platform enables us to track care at the patient level and program-wide. With DSRIP funding, we will scale this platform to coordinate care for at least 1000 BH CP enrollees and connect our BH SDH partners' EHRs further knitting together our teams to operate more efficiently and effectively for assigned BH CP enrollees.

As mentioned in the previous section, the BH CP NCM will use claims to identify the key members of the enrollee's BH CP Team and ask the enrollee if there are team members from DMH or DDS to include. We will also work with the DMH Homeless Outreach Team to coordinate with those enrollees in DMH care. During the first case conference with the enrollee and BH CP Team, we will identify the BH CP core team members and their roles in helping to advance the goals on the Patient Centered Care Plan. It will be the BH CP Care Coordinator's role to facilitate communication between core team members to progress toward achieving these goals. For BH CP Team members, the data platform will serve as a vital communication tool. For providers that are external to the Consortium, the BH CP Care Coordinator will work with these providers to host the case conference, or at minimum, engage them via phone during the case conference. The BH CP Care Coordination Team (NCM and Care Coordinator) will communicate routinely via secure Epic EHR, email, or phone calls regarding essential information including updates to the Person Centered Care Plan. If the BH CP Care Coordinator is facing challenges working with the BH CP Team, the BH CP NCM or the BH CP Medical Director is available to intervene to ensure that the BH CP Team is responsive to advancing Patient Centered Care Plan goals and BH CP goals.

BH CP Care Coordination Team's responsibility is the implementation of the Person-Centered Care Plan (with active enrollee involvement). The BH CP Care Coordinator (with support from the NCM as needed) will ensure appropriate linkages, referrals, coordination and follow up to needed services and supports, including referral and linkages to LTSS. Specific activities include, but are not limited to, appointment scheduling, conducting referrals and follow up monitoring, participating in hospital discharge processes and communicating with other providers and clients/family members—all of these activities will be documented in our shared data platform through ETO. Our shared data platform will be a tremendous support for Care Coordinators in finding their BH CP enrollees (in shelters, in clinics, day treatment programs, etc.) and communicating to BH CP Team members across the Consortium. If BH CP Team members are external to the Consortium, the BH CP Care Coordination Team will communicate via secure email.

BH CP Team Case conferences will be held within the first 3 months and then every 6 months or more often if needed and will be the main vehicle for keeping BH CP Teams focused on Patient Centered Care Plan goals. The BH CP Care Coordinator's role is to convene these case conferences and to encourage and accompany the enrollee to the meeting if needed to ensure that the enrollee stays engaged. Each BH CP Care Coordinator will be required to make face-to-face contact with each enrollee on his/her caseload (~35-45 enrollees) at least 1/month (more if the enrollee is in crisis) and document all encounters. Currently in ETO, we collect data on the number and kinds (telephone, face to face, etc.) of "encounters" to better understand the intensity of service needs—we will continue this practice in our BH CP.

The BH CP NCM's role is to support the 4 Care Coordinators under his/her supervision and oversee the combined panel (~165 enrollees) focusing on medical, substance use, and mental clinical outcomes; recommending stepped care which is adjusting services or moving to a higher level of intensity as needed[7]; reviewing and approving Patient Centered Care Plan changes;

[7]http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438

collaborating with the Program Manager; and serving as clinical support for the CP Team. If a PCP or BH clinician is a provider external to our Consortium, the NCM will communicate via Epic EHR, email, or phone.

4. Care Transitions

The SDH BH CP Consortium is well positioned to manage timely comprehensive care transitions. We have BHCHP RNs already embedded at BMC, MGH, Tufts, Brigham and Women's, and BHCHP's medical respite facilities (Barbara McInnis House and Stacy Kirkpatrick House); and with BH CP funds, we plan to hire 1 FTE LICSW who will share his/her time across area hospitals with psychiatric units as well as spend 20% of his/her time at Suffolk County Jails. During the months leading up to the launch of the SDH BH CP Consortium, BH CP Director and Medical Director will secure formal agreements with these hospitals with psychiatric beds for the LICSW to become credentialed and work on site to manage transitions of care. We will also meet with staff at the Suffolk County Jail for the LICSW to work on site there as well 1 day/week for the purpose of managing transitions back to the community. (Many homeless people struggle with transitions from jail to our community and back to jail. Adding modest LICSW support to the County Jails to manage care transitions would bring benefits to the community by ensuring that individuals being released from jail have timely mental health and primary care appointments and do not fall between the cracks).

These embedded staff gives our BH CP an important foothold for monitoring daily Admission, Discharge and Transfer (ADT) data on our BH CP enrollees. Embedded staff responsibilities include: monitoring daily ADT feeds for BH CP enrollees, communicating (same day) with the enrollee's BH CP Team (including PCP and BH clinician) and BH CP Care Coordination Team (NCM and Care Coordinator) through the shared data platform. If BH CP Team members are external to the Consortium, the embedded staff will communicate with these providers via Epic EHR, secure email, or phone call. The embedded RN staff will coordinated with the enrollee's assigned BH CP NCM on transitions of care planning and document any work in the shared data platform.

Our SDH BH CP Consortium understands better than any other provider the challenges of navigating discharge planning for homeless patients. We have established relationships with numerous LTSS providers including SNFs that have capacity to care for complex homeless patients particularly those with active substance use disorders; home care and social services providers that are flexible and responsive to the needs of homeless individuals; and BHCHP respite facilities' admission criteria. A key aspect of the training curriculum for our BH CP Care Coordination Team and imbedded inpatient staff will be to draw from the BHCHP's vast knowledge of community resources, care management programs, Community Partners, ACOs, and MCOs. Our BH CP Director and Program Manager will develop a resource directory for this purpose specifically with homeless enrollees needs in mind. BH CP Care coordination Teams will also be oriented in the use of web Apps including HelpSteps.[8]

Ideally, our BH CP team will begin discharge planning on Day 1 of an inpatient admission to a hospital, SNF, respite, or other facility. The enrollee will receive a face to face visit from either the BHCHP embedded inpatient staff and/or member of the BH CP Care Coordination Team during his/her admission to help us understand the enrollee's needs/preferences post discharge and engage the enrollee in decision making. The results of this visit will be documented in the enrollee's Person-Centered Care Plan which will automatically send an update to the BH CP Team. If members of the enrollee's BH CP Team are external to our Consortium, the BH CP Care Coordination Team will notify these providers by Epic EHR, email, or phone. If referrals

[8] FMI: https://www.helpsteps.com/

for services are necessary post discharge, either the BHCHP embedded inpatient staff and/or member of the BH CP Care Coordination Team will facilitate a warm 'referral' hand-off prior to discharge if possible. Otherwise, the BH CP Care Coordinator will arrange for the enrollee's transportation and accompany the enrollee if feasible to the service.

As One Care 'Health Homes', both BHCHP and Bay Cove understand the importance of post discharge follow-up and have developed workflows to meet follow up performance expectations with each One Care enrollee within 48 hours post discharge. We will adapt these processes to meet BH CP requirements and assign this responsibility to the BH CP NCMs. Post discharge follow-ups within 3 business days will preferably be face-to-face and occasionally by phone. We will schedule a face to face meeting, ideally coordinating during a post-discharge follow up visit with the BH CP Team (PCP or BH Clinician)—see next paragraph. During this post-discharge follow-up, whether face-to-face or phone, the BH CP NCM will conduct medication reconciliation, review discharge orders and plans, reinforce understanding of medical and behavioral health treatment plans, etc. For our One Care patients, we have adapted a script[9] from the federal Agency for HealthCare Research and Quality (AHRQ) for NCMs to ensure that the call is thorough and consistent; we plan to adapt this tool in our BH CP.

5. Medication Reconciliation

The importance of medication reconciliation post discharge cannot be overstated especially with enrollees on multiple prescriptions due to mental health, substance use, and medical diagnoses. As mentioned in the previous section, BH CP NCMs will be performing medication reconciliation within 3 business days of hospital discharge. Medication reconciliation can also happen at shelter-based clinics or street teams by NCMs already on these teams. We will use the "AHRQ" script adapted for our One Care patients as a training tool in the BH CP NCM curriculum. Our Team leads and NCMs will be able to monitor medication reconciliation performance expectations on our shared data platform to ensure that we meet this important benchmark in a timely fashion.

For homeless BH CP enrollees, supporting medication adherence requires an in depth understanding of the complexities of homeless individuals' day-to-day living and underscores the importance of having a BH CP provider with expertise in serving this population. The bidder and its Affiliated Providers have all worked with homeless individuals for decades and, together, have developed numerous strategies to address medication adherence that include:

1) Storing medications in shelter based clinics to guard against theft and to keep medications at the appropriate temperature;

2) Offering medication administration assistance at shelters in the early morning at 6 am (before guests must leave) and evenings (when guests arrive);

3) Ensuring that enrollees have access to water and food on the street to accompany medication administration;

4) Educating prescribers on options for long acting and/or oral medications, this may not be clinically optimal, but may be more practical and therefore increase medication adherence;

5) Offering translation services for enrollees as needed; and

6) When needed, providing directly observed therapy for additional medication adherence.

[9] https://www.ahrq.gov/professionals/systems/hospital/red/toolkit/postdischarge-phone.html

Our shared data platform will support medication adherence and reconciliation offering, for the first time, up to date medication lists across the continuum of care for our Consortium' BH providers, Care Coordinators, and shelter providers, etc. to be used to reinforce with the enrollee the importance of taking medications, check that the enrollees medication list is accurate, and offer education or linkages to the BH CP NCM if needed for patient or clinician support.

6. Health and Wellness Coaching

Amid the chaos of homelessness, focusing on health and wellness often becomes a distant priority. Our BH CP understands the need to slow down, stay flexible, and meet homeless individuals where they are. Enrollees are unlikely to be focused on wellness goals, when they need to find a safe place to sleep that night. During the Start-up period, we will develop and conduct a community needs assessment and survey our Affiliated Partners and select staff as well as Consumer Advisory Board to get input on gaps in services and activities that will engage enrollees in care.

The BH CP Director and Program Manager will be responsible for working with the BH Consortium Affiliated Partners and our contracted ACOs to leverage Flexible Funds to develop services that engage and are relevant to vulnerable population, but we also have dedicated a modest portion of our ICB budget for PY1-4 for Health and Wellness Programs offering us flexibility to develop programs. We anticipate expanding existing group programming such as "HER Saturdays" (Health, Empowerment, Resources) that is currently held in BHCHP's lobby on Saturday mornings. On average 60 women attend each Saturday, many of whom engage in primary and behavioral care for the first time. This program works with volunteer community partners to engage homeless women in healthy activities, safe from the street, by offering healthy snacks and beverages, rotating activities (BMC therapy dogs, trauma informed yoga, mindfulness, acupuncture, healing touch, Zumba, movies & popcorn etc.), educational activities (oral health, contraception, domestic violence etc., IT/Phone support and educational games (women's health bingo for example). These community partners include: individual volunteer practitioners from local organizations such as LEGITyoga, Cambridge Zen Center, and Boston Medical Center as well as "Hope and Comfort", who supplied donations for Bingo prizes and case management visits. This kind of programming begins the necessary trust building between providers and patients that often leads to engagement in ongoing health care. We will use the results of the community needs assessment survey to guide development of new services and update the assessment at least annually. Other examples of Health and Wellness Programs that we propose to develop including: smoking cessation, STD screening, oral cancer screening, etc.

Our BH CP Care Coordination Teams (NCM and Care Coordinator) based at our Affiliated Partners and Street Team will offer mobility for face-to-face outreach and support to those housed populations. The BH CP Care Coordination team will also add a critical layer of support to those enrollees receiving CSPECH services, working with existing case managers employed by Pine Street Inn, Boston Public Health Commission, and New England Center and Home for Veterans and other organizations as well. Integrating the BH CP Care Coordination Team with CSPECH services will ensure that physical and behavioral health care visits are prioritized and LTSS needs are met and documented in the Person Centered Care Plan.

Our SDH BH CP Consortium will develop Health and Wellness programs for groups if we have several BH CP enrollees living in a congregate housing setting or we will leverage the BH CP Care Coordination Team for one-on-one education on topics such as nutrition, disease self-management, stress management—whatever is needed to help ensure that newly housed BH CP enrollees stay on a path to maintain their housing by making healthy life choices. All these activities will be documented in the Person Centered Care Plan.

7. Connection to Community and Social Services

As mentioned in Section 7.3.C.2 our proposed SDH BH CP Consortium intake will include a thorough assessment of SDH needs via the HMIS tool and the Arizona Self Sufficiency (ASSM) Matrix (both attached.) The power of our Person Centered Care Plan is that the enrollee, working with the Care Coordinator, can select ASSM domains that are the enrollee's priorities. The BH CP Care Coordinator will enter these ASSM priority domains into the section of the Person Centered Care Plan called "Other Social Needs" as well as the interventions and referrals needed to Community and Social Services. Progress toward these goals will be tracked through a numeric score each time the ASSM is administered (every 6 months) giving the entire BH CP Team with feedback regarding progress towards connecting the enrollee to needed social services and supports. BH CP Care Coordinators will leverage community resource directories referenced earlier and free Apps such as HelpSteps to identify community programs – our SDH BH CP Consortium training will introduce and review these resources at orientation. As we work with the enrollees to develop the Patient Centered Care Plan, we will provide them with options that describe the availability of these resources and identify enrollee preferences. We will track whether or not referrals for community-based services were successful and whether the enrollee is engaged and satisfied with the care.

BHCHP embedded inpatient staff will provide expert transitional support services working with the facility staff and the enrollee face-to-face to transition the homeless enrollee into community settings. Our staff understands how to navigate transitions from inpatient settings into shelter and other transitional settings such as medical respite and SNFs ensuring that the enrollee is safe and mitigating the risk for a readmission. These embedded staff will communicate to the BH CP Team through the Person Centered Care Plan which will electronically alert the BH CP Team. We will also use Epic EHR or email updates to external providers. We will prioritize setting up enrollees a face-to-face visit from the BH CP Care Coordination Team within 3 business days following discharge and track this metric in our data platform; all enrollees will have a follow-up appointment with a PCP or BH clinician within 7 days post discharge—again a metric that we will track on our shared data platform. (Seven day post-discharge primary care follow-up for vulnerable patients with complex needs has been found to lower 30-day readmission rates.[10]) The BH CP Care Coordinator will arrange transportation if needed, and if feasible, accompany the enrollee to the 7-day post discharge appointment, which can often be accomplished at the shelter where the patient is staying.

8. Community Collaboration and Coordination

The BH CP Director, Medical Director, and CEO will meet with community based organizations in the Boston Prime service area in the Start-up/Preparation period including the Department of Mental Health to discuss opportunities for collaboration. As longstanding service providers, BHCHP and Affiliated Providers already have strong working relationships with community service providers that provide mental health, substance use services, LTSS, social services, housing support, etc. We will pool our lists of providers in the Start-up/Preparation period to share our experiences, identify providers that we would like to contract with, and highlight where we need to strengthen gaps in care. This process for identifying gaps in services will also be informed by a community gap assessment survey that we will develop and administer to Affiliated Partners and their staff as well as our Consumer Advisory Board in the Start-up Period.

We have budgeted time for our BH CP Medical Director to meet with PCPs, BH clinicians, and specialists in the Boston Prime Service Area to discuss the BH CP program, especially for those that are external to our BH CP. We have time in the Start-up/Preparation period for this work and

[10]Jackson, C., et al. Timeliness of outpatient follow-up: an evidence-based approach for planning after hospital discharge. Ann Fam Med, 2015. 13(2): p. 115-22.

then ongoing. The BH CP Medical Director will help establish buy-in for the BH CP program, and for external PCP and BH clinicians gather their input for the most useful forms of communication including venues for case conferences, shared care plan development, etc.

If enrollees assigned to our SDH BH CP Consortium have a CBFS provider, we will note this on the Person Centered Care Plan and add this provider as part of the BH CP Team notifying the provider through automatic emails when case conferences are scheduled and with the enrollee's consent, providing them with a copy of the Patient Centered Treatment Plan.

7.3.D Innovative technologies for service delivery

Our most innovative technological tool for SDH BH CP Consortium will be our shared data platform (described in detail in Section 7.3.C) that will integrate housing, social service data with medical and behavioral health data in a cross-sector effort to coordinate care for enrollees experiencing homelessness. It will be a central feature of our BH CP model and provide communication, documentation, and performance feedback and monitoring for BH CP Teams and SDH BH CP Consortium. It will leverage existing care management software already supplied by the City of Boston to the Bidder and each Affiliated Partner (ETO) for communication between providers and will send automatic electronic communications to providers named on the Patient Centered Care Plan when updates are made. In addition, we plan to leverage free existing technology such as smart phone Apps including HelpSteps. We will be leveraging DSRIP funds to connect our Affiliated Partners EHRs to this platform adding pertinent data from BHCHP EHR.

We are also budgeting 35 smartphones for our BH CP Care Coordination Teams (NCM and Care Coordinators) and BHCHP embedded inpatient staff and 5 laptops to share to help them with their responsibilities of providing expedient communication and timely documentation. These staff will have the ability of conducting and uploading assessments such as the HMIS and Arizona Self Sufficiency Matrix (ASSM) on the laptop while based in settings throughout the community.

7.3.E Personnel and staffing

1. & 2. See Attachment 1: *Combined* Organizational Chart and Staffing plan

3. Recruitment Plans

Most of the recruitment and hiring responsibilities for the SDH BH CP Consortium will be conducted by BHCHP. Our Affiliated Partners will have responsibility for hiring Care Coordinators that will be based at their sites. We anticipate with 1000 MassHealth BH CP enrollees, approximately 52% or 12/23 BH CP Care Coordinators will be hired by our Affiliated Partners which will account for 1-2 FTEs BH CP Care Coordinators per Affiliated Partner. Our Affiliated Partners will follow their own recruitment and hiring policies adapting the job description for Care Coordinators to fit their organizational needs.

As the Bidder, BHCHP will provide all administrative support, all Nurse Care Manager support, and approximately 48% of Care Coordinator support. BHCHP's experience in overseeing and managing an integrated care coordination model with community-based partners is evident in our current HPC HCII pilot. As mentioned previously in Section 7.3, the HPC HCII pilot is our training ground for our MassHealth BH CP program. There are core administrative staff that are supported in the HPC HCII that are experienced and on board who will transition to the SDH BH CP Consortium.

Personnel for Preparation/Start-up Period: Some staff positions needed for the Preparation/Start-up Period are currently filled and actively engaged with the HPC HCII pilot providing the SDH BH CP Consortium with seasoned, ready experience.

BH CP Director (Takach): Ms. Takach is currently directing the on-time planning, launch, and implementation of HPC HCII pilot at 20% FTE. She will add 50% of her time to direct the SDH BH CP Consortium planning/start-up period commencing in November 2017.

BHCHP Senior Management Staff (Bock, Gaeta, De Las Nueces, Lawrence): Key members of BHCHP's SMT will devote 5% of their time working with Ms. Takach during the planning/start-up period providing strategic direction around ACO, MCO contracting; Affiliated Partners communication; provider engagement (internal to BH CP and external as well); IT vendor contracting and supervision; and personnel recruitment.

IT/Data analyst (Hass): Currently, Mr. Hass is providing IT/data analytic support to the HPC HCII pilot at 20% FTE. He will add 50% of his time to working with Ms. Takach on the SDH BH CP Consortium Preparation/Start-up Period commencing in November 2017.

Timeline for Staff Recruitment November 2017-April 2018

Ms. Saacke (BHCHP Human Resources Director) will vet several Recruitment Consultants beginning in November 2018 who will be responsible for marketing and advertising the positions, as well as screening, assessing and making recommendations regarding the candidates for new positions needed for BH CP Launch. The Recruitment Consultant will be available to offer expert advice to our Affiliated Partners on recruitment and screening if desired. Working with Ms. Takach and Mr. Bock, Ms. Saacke will contract with a Consultant by December 2017.

Ms. Saacke will work with the Recruiter to post and advertise job positions in December 2017; first round interviews will take place in January 2018. Ms. Adams, Ms. Takach and other members of the BHCHP senior management team will conduct final interviews as needed in February 2018 and will make offers in late February for March 15, 2018 start.

We anticipate 33 new positions for our SDH BH CP Consortium. 19 will be BHCHP employees and 12 will be Affiliated Partners' employees:

2 Team Leads (see attachment 2)

6 Nurse Care Managers (see attachment 3)

23 Care Coordinators (see attachment 4)

1 LICSW Psychiatric Hospital Liaison (see attachment 5)

1 Program Manager (see attachment 6)

Implementation Period: April 2018—

Training will commence in mid-late May 2018 to allow new staff to focus on month 1 (June 2018) to outreach and enrollment efforts.

4. How we will recruit and hire staff from cultural and linguistic communities: In conjunction with the contracted Recruitment Agency, the Bidder will reach out to community agencies to seek assistance broadening our recruitment pool. The Bidder will also work with our internal Diversity and Inclusion Committee to assist us with seeking out additional candidates.

BHCHP compensates bilingual and multilingual staff at a higher rate for the following languages: Spanish, Haitian Creole and Portuguese.

5. Proposed Training: BHCHP provides an orientation to all new staff members and our Affiliated Partners will follow their own internal orientation policies. BHCHP internal orientation includes:

Benefit and Policies Orientation: During the first week, all employees will attend a Benefit and Policies Orientation at which basic BHCHP policies, compensation and benefits programs, as well as other information necessary to all employees at BHCHP, will be reviewed. All documentation required as a condition of employment will be collected and all necessary paperwork, such as medical benefit plan enrollment forms, beneficiary designation forms and appropriate federal and state tax forms will be completed and collected. All BHCHP employees are expected to attend a BHCHP-wide formal orientation training session, which is held monthly. Supervisors will schedule all employees to attend this training during their orientation period. At this orientation BHCHP policies are reviewed. We encourage questions during the orientation, as well as at other times, so that employees will understand all the guidelines that affect and govern the employment relationship. In addition, each employee has an orientation to the employee's position. This orientation and training is managed by the employee's direct supervisor. During this orientation, important information will be shared regarding the performance requirements of the position.

As the Bidder, BHCHP will be responsible for providing BH CP program orientation for *all employees hired for the SDH BH CP Consortium*. In addition, we will have BHCHP imbedded inpatient staff, select members of the BH CP Teams attend trainings as well. Following is our proposed training plan for BH CP staff drawing from the curriculum for our HPC HCII pilot. Faculty will mostly draw from BHCHP staff.

SDH BH CP Consortium Learning Collaborative (~3 day training)

Part I – Introduction (2.5 hours)

> **Explanation of SDH BH CP Consortium** (45 minutes)
> Facilitated by: Barry Bock (BHCHP CEO) and Mary Takach (BHCHP Senior Health Policy Advisor). Includes: Purpose, goals and components of MassHealth BH CP program; performance expectations
>
> **BH CP Team Introductions** (45 minutes) Role of NCM, Care Coordinators, Health Team Leads. Facilitated by: BH CP Director
>
> **Social Determinants of Health** (30 minutes)
> Facilitated by: Jessie Gaeta (BHCHP CMO) or Denise De Las Nueces (BHCHP Medical Director)
>
> **Consumer Advisory Board Member Presentation** (30 minutes)
> Facilitated by: CAB member

Part II – Navigation and Documentation (12.5 hours)

> **Navigating the Healthcare System** (4 hours)
> Facilitated by: Gabriel Wishik (BHCHP physician) and Sarah Ciambrone
> Includes: BHCHP embedded inpatient staff roles, Medication adherence, provider roles, case conferencing, appointment coordination; staff safety

Connecting with BH CP Care Teams (1 hour 30 minutes)
Facilitated by: CP Care Members
Includes: Speed Dating activity with members of the BH CP teams; how and when to communicate

Dealing with Health Crises (1.5 hours)
Facilitated by: TBD

Dealing with Psychiatric Crises (1.5 hours)
Facilitated by: Billie Starks, LICSW and Esther Valdez, MD

Participation/Consent Process, Intake Assessments (HMIS and ASSM), Person Centered Care Plan, Data Platform, and ETO (3 hours 15 minutes)
Facilitated by: Mary Takach & BHCHP IT Dept.
Includes: Consent process, importance of proper documentation in platform, IT lab session; filling out intake assessments

PHI/HIPPA and Cortext (45 minutes)
Facilitated by: Dirk Williams (BHCHP Compliance Officer) and Keith McInnes
Includes: Overview of PHI/HIPPA information; secure messaging practices

Part III – Motivational Interviewing (7 hours)
Facilitated by: TBD

6. Staff retention

BHCHP strives to attract and retain motivated, high-performing staff by through the following strategies:

1. Promote retention and satisfaction of high-performing staff by empowering them: providing clarity on expectations; holding all staff accountable for doing their best work; including staff members in strategizing and decision-making where possible and being transparent where not possible.

2. Maintain a competitive compensation and benefits package, designed to attract and retain a high-performing, mission-oriented staff.

3. Remain compliant with all relevant regulations and requirements; communicating these clearly and consistently upholding these standards with all staff.

4. Commit to a performance management system that supports individual and team growth, accomplishment, and satisfaction.

5. Prioritize a safe working environment, support by training, technical features, policies and continuous assessments that put safety first.

7.3.F Implementation Plan and Timeline

Preparation/Start-up

November 1, 2017-May 31, 2018

When?	What?	Who?

November-December 2017	1. Meet with CEOs of ACOs & MCOs; Execute Contractual Agreements for BH CP Services	1. CP Director (Takach), CEO (Bock), CFO (Leung)
	2. Hire and train new staff position for recruitment to work with both BHCHP and Affiliated Partners	2. CP Director (Takach) & Human Resources Director (Saacke), HR from the Affiliated Partners
	3.Finalize contract with Green River, the IT Vendor; develop schedule/workplan to connect Affiliated Partners EHRs to data platform	3. CIO (Lawrence), IT (Haas) working with IT/Data Analytics and IT leads from Affiliated Partners.
	4. Further develop & Administer Gap Assessment Survey for Affiliated Partners and CAB. Purpose: identify resources needed to serve BH CP enrollees and inform Health & Wellness Program activities	4. CP Director (Takach) working with CMO (Gaeta), and Affiliated Partners Senior Leadership
	5. Secure formal agreements with hospitals that have psychiatric beds for the LICSW to work on site for the purpose of managing care transitions. In addition, meet with senior staff at DMH and DDS to discuss ways to further collaborate in BH CP program.	5. CEO (Bock) BH CP Director (Takach) and Medical Director (De Las Nueces) and BHCHP Chief Psychiatrist (Valdez)
January-May 30, 2018	1. Primary Care Provider and Behavioral Health Clinicians "Roadshows": Informational outreach to providers about SDH BH CP Consortium	1. CEO (Bock), CMO (Gaeta), and Medical Director (De Las Nueces); BH CP Medical Director (TBD)
	2. Interview and hire BH CP staff with May 15, 2018 expected start date	2. BH CP Director (Takach), & BHCHP Senior Management Staff; Affiliated Partner staff
	3. Connect Affiliated Partners EHR to Data Platform; modify Shared Data Platform to add BH CP performance metrics	3. CIO (Lawrence) and IT/Data Analyst (Haas)working with Green River Vendor
	4. Further develop training curriculum for May 2018 BH CP Learning Collaborative; secure training site and faculty	4. BHCP Director (Takach) and BHCHP and Affiliated Partners Senior Leadership
	5. Using data from MassHealth describing identified BH CP enrollees [assuming, as described in previous section, that this data is available], convene meetings to develop outreach and enrollment protocol for Bidder and Affiliated Partners to achieve rapid enrollee participation in BH CP program..	5. CP Director (Takach) working with CMO (Gaeta), COO, and Affiliated Partners Senior Leadership and designees

	Analyze MassHealth Potential BH CP enrollees list to determine existing relationships and assign likely "BH CP Care Coordination Homes" for enrollees.	
	8. New BH CP staff begin May 15. Each Consortium site conducts internal staff orientation.	8. The Bidder and Affiliated Partners will conduct their own program orientation process.
	9. Conduct Learning Collaborative for BH CP Teams in late May; evaluate Learning Collaborative to identify topics for future bimonthly trainings/learning needs.	9. BH CP Director (Takach) and BHCHP Senior Management Team consulting with Affiliated Partners Senior Leadership
Y1 1st/3 Quarters	1. Rollout Outreach and enrollment strategic plan using protocol developed in Start-up/Prep period to achieve enrollee participation in BH CP program. After participation form is signed and uploaded by member of BH CP team into shared data base, BH CP Care Coordination Team will be notified through electronic reminder from database.	1. BH CP Director (Takach), Program Manager BH CP Teams (all participating agencies)
	2. Within 3 calendar months of assignment of enrollee to the SDH BH CP Consortium, complete comprehensive assessment, team conference, and Person Centered Treatment Plan.	2. BH CP teams; Program Manager, Team Leads, oversight
	3. Monthly reporting to MassHealth by Bidder on Member Status Reports. Payments to Affiliated Partners for CP Supports and ICB infrastructure.	3. CFO (Leung) working with BHCHP Finance Team
	4. At least monthly face to face engagement of enrollees working toward Person Centered Treatment Plan goals; documentation of all	4. BH CP Care Coordination Team working in partnership with BH CP Teams (PCPs, BH clinicians, other providers)

	qualifying activities	
	5. Begin Monthly Quality and Efficiency Committee (QEC) to discuss BH CP quality and utilization metrics and report findings to Consortium at monthly meetings.	5. CMO (Gaeta) and or Medical Director (De Las Nueces) working with Program Manager, Team leads and QEC Committee.
	6. Monthly Consortium meetings to discuss enrollment, data platform dashboard metrics as well as MassHealth metrics, service needs, strategies to meet needs and improve BH CP performance	6. BH CP Director (Takach), Program Manager, working with BHCHP and Affiliated Partners Senior Leadership
	7. Bimonthly Consumer Advisory Board Meetings	7. BH CP Director, CEO (Bock) and Program Manager
	8. Bimonthly CP team training	8. Program Manager working with CP Director (Takach) and BHCHP and Affiliated Partners Senior Leadership
	9. Submit Annual Quality Improvement Plan to EOHHS	9. CMO (Gaeta) working with Associate Director of Clinical Operations (Giles), BH CP Director (Takach) and Affiliated Partners' Senior Leadership
	10. Analyze Gap Assessment Data. Begin planning of Health & Wellness programs as part of Engagement strategy for the first and second quarter of Y1	10. CP Director (Takach) working with CMO (Gaeta), and Program Manager with Affiliated Partners Senior Leadership
Y1 2nd/3 quarters	1. Activities 1-8 described in **Y1 Q1**	1. Staff designated for activities 1-8 in **Y1 Q1**
	2. Implement Health And Wellness Program activities at select sites with high concentrations of homeless enrollees; document all enrollee engagement in data platform; evaluate findings, revise strategies as needed.	2. Team leads (working with Program Manager and BH CP Nurse Care Managers; BH Care Coordination Teams, Program Manager

Y1 3rd/3 quarters	1. Activities 1-2 described in **Y1 Q2**.	1. Staff designated for activities 1-2 in **Y1 Q2**
	2. Biannually update Person-Centered Care Plan (or more) convening case conferences as needed and reassess enrollee self-function utilizing the Arizona Self Sufficiency Matrix—track progress on scores	2. Care Coordination Team working with BH Care Team and enrollee
	3. Biannually provide payments from Affiliated Partner Incentive Pool to support performance management activities Evaluate Affiliated Partners performance based on agreed upon percentage by Consortium in documenting and meeting Qualifying Activity expectations.	3. CFO (Leung) working with BH CP Director (Takach) and Affiliated Partners toward agreed upon allocations.
	4. Submit Annual Report to EOHHS	4. BH CP Director (Takach) and CFO (Leung) working with Program Manager and Finance Staff
Y2 Q1	1. Activities 1-2 described in **Y1 Q3**.	1. Staff designated for activities 1-2 in **Y1 Q3**
	2. Scale BH CP beyond 1000 to accommodate more homeless enrollees adding CP team staff as needed.	2. BH CP Director (Takach) working with BHCHP and Affiliated Partners Senior Management
	3. Update & Administer Gap Assessment Survey for Affiliated Partners and CAB. Purpose: identify resources needed to serve BH CP enrollees and inform Health & Wellness Program activities	3. Program Manager working with BH CP Director (Takach)
	4. Submit Annual Quality Improvement Plan to EOHHS	4. CMO (Gaeta) working with Associate Director of Clinical Operations (Giles), BH CP Director (Takach) and Affiliated Partners' Senior Leadership
Y2 Q2	1. Activities 1-2 described in **Y1 Q3**.	1. Staff designated for activities 1-6 in **Y1 Q3**

	2. Biannually provide a portion of withhold payments returned to support Affiliated Partners' performance management activities. Evaluate Affiliated Partners performance based on agreed upon percentage by Consortium in documenting and meeting Qualifying Activity expectations.	2. CFO (Leung) working with BH CP Director (Takach) and Affiliated Partners toward agreed upon allocations.
Y2 Q3	1. Activities 1-2 described in **Y1 Q3**.	1. Staff designated for activities 1-2 in **Y1 Q3**
Y2 Q4	1. Activities 1-2 described in **Y1 Q3**.	1. Staff designated for activities 1-6 in Y1 Q3
	2. Biannually provide a portion of withhold payments returned to support Affiliated Partners' performance management activities. Evaluate Affiliated Partners performance based on agreed upon percentage by Consortium in documenting and meeting Qualifying Activity expectations.	2. CFO (Leung) working with BH CP Director (Takach) and Affiliated Partners toward agreed upon allocations.
	3. Submit Annual Report to EOHHS	3. BH CP Director (Takach) and CFO (Leung) working with Program Manager and Finance Staff
Y3 Q1	1. Activities 1-2 described in **Y1 Q3**.	1. Staff designated for activities 1-2 in **Y1 Q3**
	2. Explore feasibility of reducing FTE% of IT/Data Analytics staff and (1) Team Lead by consolidating staff roles to reflect reductions in DSRIP payments.	2. CP Director (Takach) working with CIO (Lawrence) and (COO)
	3. Submit Annual Quality Improvement Plan to EOHHS	3. CMO (Gaeta) working with Associate Director of Clinical Operations (Giles), BH CP Director (Takach) and Affiliated Partners' Senior Leadership

Y3 Q2	1. Activities 1-2 described in Y1 Q3.	1. Staff designated for activities 1-6 in Y1 Q3
	2. Biannually provide a portion of withhold payments returned to support Affiliated Partners' performance management activities. Evaluate Affiliated Partners performance based on agreed upon percentage by Consortium in documenting and meeting Qualifying Activity expectations.	2. CFO (Leung) working with BH CP Director (Takach) and Affiliated Partners toward agreed upon allocations.
Y3 Q3	1. Activities 1-2 described in **Y1 Q3**.	1. Staff designated for activities 1-2 in **Y1 Q3**
Y3 Q4	1. Activities 1-2 described in **Y1 Q3**.	1. Staff designated for activities 1-6 in Y1 Q3
	2. Biannually provide a portion of withhold payments returned to support Affiliated Partners' performance management activities. Evaluate Affiliated Partners performance based on agreed upon percentage by Consortium in documenting and meeting Qualifying Activity expectations.	2. CFO (Leung) working with BH CP Director (Takach) and Affiliated Partners toward agreed upon allocations.
	3. Submit Annual Report to EOHHS	3. BH CP Director (Takach) and CFO (Leung) working with Program Manager and Finance Staff
Y4 Q1	1. Activities 1-2 described in **Y1 Q3**.	1. Staff designated for activities 1-2 in **Y1 Q3**
	2. Submit Annual Quality Improvement Plan to EOHHS	2. CMO (Gaeta) working with Associate Director of Clinical Operations (Giles), BH CP Director (Takach) and Affiliated Partners' Senior Leadership
Y4 Q2	1. Activities 1-2 described in **Y1 Q3**.	1. Staff designated for activities 1-6 in Y1 Q3

	2. Biannually provide a portion of withhold payments returned to support Affiliated Partners' performance management activities. Evaluate Affiliated Partners performance based on agreed upon percentage by Consortium in documenting and meeting Qualifying Activity expectations.	2. CFO (Leung) working with BH CP Director (Takach) and Affiliated Partners toward agreed upon allocations.
Y4 Q3	1. Activities 1-2 described in **Y1 Q3**.	1. Staff designated for activities 1-2 in **Y1 Q3**
Y4 Q4	1. Activities 1-2 described in **Y1 Q3.**	1. Staff designated for activities 1-6 in **Y1 Q3**
	2. Biannually provide a portion of withhold payments returned to support Affiliated Partners' performance management activities. Evaluate Affiliated Partners performance based on agreed upon percentage by Consortium in documenting and meeting Qualifying Activity expectations.	2. CFO (Leung) working with BH CP Director (Takach) and Affiliated Partners toward agreed upon allocations.
	3. Submit Annual Report to EOHHS	3. BH CP Director (Takach) and CFO (Leung) working with Program Manager and Finance Staff
Y5 Q1	1. Activities 1-2 described in **Y1 Q3**.	1. Staff designated for activities 1-2 in **Y1 Q3**
	2. Work to reduce IT/Data Analytics staff to 25% FTE and explore phasing out DSRIP support of (1) Team Lead by consolidating staff roles to reflect reductions in DSRIP payments	2. CP Director (Takach) working with CIO (Lawrence) and COO
	3. Negotiate with ACOs and MCOs for new contract cycle	3. CEO (Bock), CFO (Leung), BH CP Director (Takach), CMO (Gaeta)
	4. Submit Annual Quality Improvement Plan to EOHHS	4. CMO (Gaeta) working with Associate Director of Clinical Operations (Giles), BH CP Director (Takach) and Affiliated Partners' Senior Leadership

Y5 Q2	1. Activities 1-2 described in **Y1 Q3**.	1. Staff designated for activities 1-6 in **Y1 Q3**
	2. Biannually provide a portion of withhold payments returned to support Affiliated Partners' performance management activities. Evaluate Affiliated Partners performance based on agreed upon percentage by Consortium in documenting and meeting Qualifying Activity expectations.	2. CFO (Leung) working with BH CP Director (Takach) and Affiliated Partners toward agreed upon allocations.
Y5 Q3	1. Activities 1-2 described in **Y1 Q3**.	1. Staff designated for activities 1-2 in **Y1 Q3**
Y5 Q4	1. Activities 1-2 described in **Y1 Q3**.	1. Staff designated for activities 1-6 in **Y1 Q3**
	2. Biannually provide a portion of withhold payments returned to support Affiliated Partners' performance management activities. Evaluate Affiliated Partners performance based on agreed upon percentage by Consortium in documenting and meeting Qualifying Activity expectations.	2. CFO (Leung) working with BH CP Director (Takach) and Affiliated Partners toward agreed upon allocations.
	3. Finalize ACO/MCO contracts for new contract cycle	3. CEO (Bock), CFO (Leung), BH CP Director (Takach), CMO Gaeta
	4. Submit Annual Report to EOHHS	4. BH CP Director (Takach) and CFO (Leung) working with Program Manager and Finance Staff

Section 7.3.H Sustainability

Funding for BH CP Supports and Infrastructure and Capacity Building (ICB) investments provided during the Start-Up/Preparation Period (and the first five years of the BH CP program) will enable our SDH BH CP Consortium (comprised of nine community-based organizations) to invest and build capacity that will firmly integrate our organizations and elevate our service delivery to a new level.

Five years will enable us to get our data platform fully functioning resulting in major efficiencies across the system. By using ICB funding to maximize the capacity of our data platform, we will be able to fully describe our enrollee population, the services they received, the encounters. and the progress toward goals. Our data platform will be maximized in many ways using ICB funding:

- The ICB funding will be used to connect BHCHP and Affiliated Partners' EHRs to the data platform. This will result in the automatic collection and aggregation of limited but necessary amounts of medical, mental health, substance use, housing/shelter, and social service data that will support multi-disciplinary coordination. This will also reduce duplication of services and increase efficiency. Efficiency is the key to sustainability.
- The data platform will combine EHR data with intake assessments which will populate the Patient Centered Health Record thereby reducing clinical staff time with double data entry.
- The data platform will be developed to automatically generate a monthly report that will aggregate Member Status Reports from nine Consortium partners into one template to streamline reporting to EOHHS thereby minimizing burden on billing and finance staff.
- The data platform will be developed to generate quality and efficiency reports to analyze and track BH CP patient-specific metrics. Data will also be available at the BH CP Care Coordination Team level, site level, and program-wide, thereby reducing the time IT/Data Analytics staff are needed to generate reports.

Five years provides us with resources to orient staff *and* organizations across multiple sectors towards productive, regular patterns of communication and coordination. We will break down walls through training, protocols, electronic communication, etc. The result will be collaboration toward shared goals of meeting the needs of homeless individuals with SMI, SUD, and complex medical conditions. We will sustain ongoing training by developing tools such as webinars and modules that can be used for future staff; we will develop protocols to be adopted and used across organizations that will become a part of each organization's culture of doing business; and we will develop a data platform that will instantly message members of the integrated BH CP Team enhancing communication. Ultimately, we will be rewriting the ways that organizations and Teams are meant to work with each other.

Five years will give us opportunity to use ICB funding to help BHCHP and Affiliated Partners to develop performance management skills by qualifying for Accountability payment from achieving acceptable scores and sharing a portion of this payments returned from our withholds. By providing modest performance payments and encouraging healthy competition amongst each other through transparent reporting, we feel that we will build capacity that will help us negotiate with ACOs and MCOs for competitive rates post-DSRIP and qualify for performance payments that will replace these ICB payments.

There are certain ICB investments that are core to BHCHP's mission that we are prepared to sustain after ICB support has ended. In Y1 of ICB funding, the Health and Wellness Program Pool is budgeted at its highest level ($60,000) to engage homeless enrollees in the BH CP. The goal is to build meaningful relationships, and help provide services that introduce healthy problem-solving and healthier choices. We are excited to be able to develop a rich array of programs that serve homeless BH CP enrollees. BHCHP will be offsetting any decline of ICB funding for the Health and Wellness Programs Pool with a corresponding increase from BHCHP operational and development funds to maintain funding levels at or around $60,000 over the five years. We plan to collect data on each of the Health and Wellness Programs to be able to analyze outcomes and to be able to make the case to continue effective programs with ACO and MCO flexible funding. Regardless of the support, if the programs are effective, BHCHP will continue the funding.

We think as we stand up our BH CP, approach a full capacity of engaged enrollees, automate IT systems and documentation, we might be able to consolidate a Team lead position and phase down IT/Data Analyst time.

We are confident that our BH CP model will prove effective improving health outcomes and decreasing costs. We believe that we will be able to build the case such that ACOs and MCOs will want to contract with our SDH BH CP Consortium once DSRIP funds expire.

MassHealth along with the ACOs and MCOs will be getting a BH CP partner that will care for some of the most complex, expensive MassHealth enrollees in the Commonwealth. It is our belief that the foundational support provided to our SDH BH CP Consortium will allow us to develop and hone care coordination that will prove indispensable to the system as a whole and to our patients.

7.3.I Quality Management and Performance Monitoring

1.A Description of the Bidder's quality improvement program

The mission of the Bidder, BHCHP, is to assure access to high *quality* health care for vulnerable individuals especially homeless individuals and families in the Boston area, and this charge will be the basis for quality management activities for the BH Community Partners program. This mission mandates excellence and equity in the provision of primary and preventive health care, mental health, and addiction services and has required creativity and extraordinary collaboration with virtually all public and private health care agencies and providers in Boston. The program works toward achieving this mission in three ways:

1. To provide the **"glue"** between the shelter/housing community and the health care system;

2. To become a **"catalyst"** within the mainstream to help the health care system address the special needs of individuals and families whose health is often determined by abject and persistent poverty and complicated by unsafe and insecure housing;

3. To serve as a **"bridge"** between medicine and public health, a model of primary and preventive care to individuals and families addressing the harsh public health and communicable disease risks faced by impoverished populations living in crowded shelters and on the city's streets.

BHCHP has a history of quality activities resulting in ongoing improvement in the access and quality of the medical care that is delivered to our underserved clients, and this infrastructure will provide the foundation for quality management within the SDH BH CP Consortium.

Health Disparities**.** A driving force behind BHCHP's quality plan is the elimination of health disparities. Homeless people are some of the most marginalized and disenfranchised people in America. Living in poverty, our patients suffer the public health risks similar to other poor populations. The vulnerabilities of life on the streets and in shelters leave our patients more susceptible to communicable disease and chronic illness.

While our primary focus is disparities related to economic status, we are attuned to the confounding role race and ethnicity can play in health outcomes. Our reporting system allows for comparison of quality indicators by racial and ethnic subgroups, and in the past, no significant differences have been noted. This will continue to be a valuable tool in our SDH BH CP Consortium.

Additionally, we see the profound effect of experiencing homelessness on the health status of our patients. To this end we have engaged numerous housing partners in the SDH BH CP Consortium to enhance housing opportunities for our patients. We provide continuation of patient care for those in housing in an effort to help them preserve their tenancies. We have also seen that housing can result in improvement in quality indicators.

Key Quality Measurements. Each year BHCHP selects, through an interdisciplinary process and based on regulatory requirements, the key measurements and goals that will be focused on for the upcoming year. For 2017 and beyond, we are focused on ACO quality measures. For all quality indicators, we establish an annual goal. In addition to these program-wide goals, each site/team can choose other measures that the group feels needs to be of concentration. Metrics range from preventive care measures such as cervical and breast and colon cancer screening, chronic disease management metrics such as hypertension and diabetes control, to behavioral health measures including depression and anxiety screening, as well as access to pharmacological treatment for SUD and prescribing of naloxone rescue kits. In all, our program tracks 14 program-wide metrics, in addition to dozens of team- or site-specific measures.

BHCHP's Quality Data Analyst is charged with tracking data and producing reports for constant feedback to individual clinicians and teams. For reports that require inputs from Medicaid raw claims data for patients attributed to BHCHP, a specific Data Analyst with expertise in claims analysis performs these analyses. Individual team members and sites can monitor their quality improvements through transparent reports embedded in the electronic health record.

We maintain National Committee for Quality Assurance (NCQA) Level III Patient Centered Medical Home (PCMH) recognition for our BMC clinic at JYP, as well as two shelter-based teams at Pine Street Inn and Saint Francis House. In addition, BHCHP has been designated a Massachusetts Health Policy Commission (HPC) "PCMH PRIME" practice in 2016. This designation enhances NCQA's recognition program with the addition of 13 behavioral health integration criteria.

2. A description of at least one quality initiative the Bidder proposes to undertake in Budget Period 1, including measures for success.

The SDH BH CP Consortium will adopt **Follow-Up After Hospitalization for Mental Illness (7-day)** as the first metric to begin tracking and working toward a goal. The metric is defined as the percentage of discharges for ACO Enrollees 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge. We choose this metric because it is one that we can analyze internally, given raw claims from the ACO, which we are already receiving, and because we have a significant opportunity to impact our enrollees' lives and performance. Our shared data platform provides a dashboard for the LICSW embedded at hospitals with psychiatric units to enter data for the BH CP Team to track this measure. The platform also provides an opportunity for BH CP Care Coordinators and the BH CP Team to post and view upcoming appointments to inform whether the enrollee needs follow-up care.

The first task at the start of the program will be to calculate the baseline performance for the population. We will then set a goal to reach within one year, with input from the SDH BH CP Consortium and BHCHP's overarching QEC. Every two months, the SDH BH CP Consortium will conduct PDSA cycles to test the effectiveness of new interventions aimed at improving this metric. Examples of PDSA cycles for this metric may include: attempting to notify BH CP care coordinators of psychiatric inpatient admissions via our proposed BH CP LICSWs who will be based at area hospitals with psychiatric units; BH CP care coordinators reach out to patients via telephone, and mobile outreach if needed, within 48 hours of discharge from the hospital in order to coordinate an outpatient mental health encounter. Performance on this metric will be reported transparently every month across BH CP case coordinators and BHCHP clinical teams.

3. The functions of the Bidder's quality committee, including the composition and reporting structure within the Bidder's organization.

The overall responsibility for the BHCHP Quality Plan lies with the BHCHP Board of Directors, and quality improvement activities specifically related to the BH Community Partners program will be embedded within BHCHP's Quality Plan. All quality activities have oversight by the Chief Medical

Officer with additional oversight roles by the Chief Operating Officer. BHCHP's Chief Medical Officer reports quarterly to the Board on current activities and progress, and this will include BH CP quality activities. The annual Quality Plan is reviewed and approved at the BHCHP Board's annual meeting.

The senior quality committee within BHCHP is the Quality and Efficiency Committee (QEC), composed of a multidisciplinary team that includes clinicians, non-clinicians, and Consumer Advisory Board (CAB) members. With the advent of the BH CP program, the BH CP Director, Program Manager, and Team Leads will join the QEC in active roles to report back on performance on BH CP-specific metrics.. This committee meets monthly and serves as the forum that coordinates and reviews all quality activities. Each year the Committee selects program-wide and team-specific quality initiatives and sets implementation plans for meeting related goals based on areas of needed improvement. The Committee regularly monitors and measures these indicators. The QEC committee members also approve the Quality Plan each year. Its composition guarantees that its activities are integrated into other areas to maximize our capabilities and avoid duplication of efforts. This committee is chaired by the Chief Medical Officer and the Chief Operating Officer. Other members of the committee include BHCHP's Quality Data Analyst, as well as various team/site leaders and BHCHP consumers.

Several other subcommittees also meet monthly and report to the QEC. These include, but are not limited to the Pharmacy and Therapeutics Committee (P&T), the Clinical Care Committee (CCC), and the Clinical Standards Committee (CSC). Each plays a key role in the organization's mission of providing quality health care and access to our clients.

The Chief Medical Officer, Chief Operations Officer, and Quality Data Analyst conduct quarterly quality update meetings at each of BHCHP's major sites/teams, and this will also include the monthly SDH Consortium Senior Leadership meetings. At these meetings the site-based quality indicators are reviewed with managers and staff. The group then chooses key areas for focused interventions using PDSA (Plan-Do-Study-Act) tools. The changes in metrics are then tracked in the next quarterly meeting and process improvement implementation is considered.

7.3.J. Coordination with ACOs and MCOs

BHCHP CEO Barry Bock and Senior Health Policy Advisor, Mary Takach have had discussions with Boston area ACO applicants including BACO, Partners, and C3, and MCOs including BMCHP, and Tufts HP regarding the work underway in the HPC HCII pilot and discussions to evolve the pilot into a BH CP program. We are currently working with BMC, BMCHP and Tufts HP to identify members that meet HPC HCII pilot criteria and enroll them in the pilot. The ACOs and MCOs expressed high interest in partnering with the SDH BH CP Consortium.

We will engage with ACOs and MCOs asking for them to refer all enrollees experiencing homelessness in the Boston-Prime Service area that meet BH CP criteria to our SDH BH CP Consortium for care coordination as well as other enrollees as deemed appropriate.

We expect to partner with the ACOs and MCOs to: 1) assign enrollees attributed to primary care from BHCHP; 2) assign enrollees to the SDH BH CP Consortium if any of their claims indicate the presence of a Z59 code (ICD 10 homeless code), and 3) assign any enrollee who is receiving CSPECH services to the SDH BH CP Consortium. If enrollees are receiving CSPECH services, that means they have been recently housed and are very vulnerable to becoming homeless again. Adding BH CP to the service mix for these enrollees would add a greatly needed behavioral health and medical support by coordinating with the existing CSPECH housing case managers. This coordination will increase the chance for these enrollees staying housed and out of the ED/hospital.

With regard to the SDH BH CP Consortium for conflict resolution, we have strong relationships already in place with hospital systems (especially BMC and MGH), existing MCOs, and many of

the potential ACO bidders. Relationships mitigate the conflicts rising to the point of needing formal resolution. In those instances in which conflict resolution occurs (which have rarely occurred), BHCHP will leverage its professional staff including compliance officer, legal counsel, finance department as well as the strong leadership provided by our CEO Barry Bock and our President Jim O'Connell.

When informal settlement efforts are not fruitful, BHCHP proposes settling disputes via arbitration and/or mediation. These methods of alternative dispute resolution save time, are more private, and cost much less than litigation, making them generally agreeable. They are also valuable in resolving disputes without burning bridges with collaborating organizations with which we need to continue working. The costs of mediation and arbitration are a small fraction of the costs associated with litigation, and even when a lawsuit has been filed, BHCHP will propose mediation and/or arbitration as a path to resolving litigation at a lower opportunity cost. Alternative dispute resolution also leads to creative and practical solutions that may be missed in traditional litigation, and agreements reached via mediation/arbitration are more likely to be successfully carried out. BHCHP's standard contracting practices include proposing binding agreements to mediate and/or arbitrate disputes arising under contracts, when appropriate and acceptable.

Community Partner Program Budget Report

The Bridge of Central Massachusetts, Inc.

Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Estimated Enrollees- Start of Period (All Enrollees)		400	1,741	2,040	2,710	3,176	
Estimated Enrollees - End of Period (All Enrollees)		1,703	1,938	2,648	3,089	3,409	
Estimated Enrollees - Monthly Average (excl CBFS enrollees)		755	980	1,490	2,031	2,394	
Estimated Enrollees - Monthly Average (CBFS enrollees only)		981	900	900	900	900	
Estimated Program Revenue (excl CBFS enrollees)		$ 951,300	$ 2,116,800	$ 3,218,400	$ 4,386,960	$ 5,171,040	$ 15,844,500
Estimated Program Revenue (CBFS enrollees only)		$ 1,716,750	$ 2,700,000	$ 2,700,000	$ 2,700,000	$ 2,700,000	$ 12,516,750
Total Estimated Program Revenue		**$ 2,668,050**	**$ 4,816,800**	**$ 5,918,400**	**$ 7,086,960**	**$ 7,871,040**	**$ 28,361,250**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -	$ -	$ -	$ -
Revenue for Operations		**$ 2,668,050**	**$ 4,816,800**	**$ 5,918,400**	**$ 7,086,960**	**$ 7,871,040**	**$ 28,361,250**

	Program Expenses		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
1	**Salary**		$ 149,375	$ 2,016,407	$ 2,680,038	$ 3,429,523	$ 4,252,970	$ 4,882,820	$ 17,411,133
2	**Fringe**		$ 37,150	$ 501,510	$ 666,562	$ 852,969	$ 1,057,772	$ 1,214,430	$ 4,330,393
	Total Personnel Costs		$ 186,525	$ 2,517,917	$ 3,346,600	$ 4,282,492	$ 5,310,742	$ 6,097,250	$ 21,741,526
3	**Training & Professional Development**		$ 2,000	$ 25,408	$ 30,469	$ 33,087	$ 25,874	$ 27,733	$ 144,571
4	**Travel**		$ 3,063	$ 68,847	$ 113,972	$ 131,291	$ 149,733	$ 162,085	$ 628,991
5	**Equipment**		$ 2,100	$ -	$ -	$ -	$ -	$ -	$ 2,100
6	**Supplies**		$ 1,553	$ 42,570	$ 44,734	$ 52,718	$ 59,684	$ 52,166	$ 253,425
7	**Contract Services** (consulting, professional)		$ -	$ 93,924	$ 127,522	$ 145,846	$ 165,358	$ 178,426	$ 711,076
8	**Software licensing**		$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	**Telecommunications**		$ -	$ 19,771	$ 26,172	$ 32,719	$ 39,685	$ 44,332	$ 162,679
10	**Occupancy** (rent, utilities, maintenance)		$ 24,828	$ 153,076	$ 331,279	$ 283,673	$ 171,373	$ 268,667	$ 1,232,896
11	**Other**		$ -	$ 20,000	$ 39,618	$ 59,100	$ 43,600	$ 23,600	$ 185,918
	Total Direct Costs		$ 220,069	$ 2,941,513	$ 4,060,366	$ 5,020,926	$ 5,966,049	$ 6,854,259	$ 25,063,182
12	**Indirect Cost/Administrative Overhead**	**12.5%**	**$ 27,509**	**$ 367,689**	**$ 507,546**	**$ 627,616**	**$ 745,756**	**$ 856,782**	$ 3,132,898
	TOTAL EXPENSES		$ 247,578	$ 3,309,202	$ 4,567,912	$ 5,648,542	$ 6,711,805	$ 7,711,041	$ 28,196,080
	Surplus/Shortfall		*$ (247,578)*	*$ (641,152)*	*$ 248,888*	*$ 269,858*	*$ 375,155*	*$ 159,999*	*$ 165,170*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2, and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Referral Coordinator	$ 55,000.00	0.5	3	$ 6,875
Senior Clinical Care Manager	$ 75,000.00	1	3	$ 18,750
Senior RN Care Manager	$ 75,000.00	1	3	$ 18,750
Clinical Care Manager	$ 60,000.00	1	3	$ 15,000
Care Coordinator	$ 45,000.00	12	2	$ 90,000
				$ -
				$ -
Total Salary (Program Budget Line 1)		**15.5**		**$ 149,375.00**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 149,375.00	25%	$ 37,150
Total Fringe (Program Budget Line 2)			**$ 37,150**

Total Personnel*	**$ 186,525**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

Referral Coordinator - Building and strengthening business relationships with ACOs/MCOs. Distribute enrollee information to care teams to engage for enrollment in preparation for Go-Live.

Senior Clinical Care Manager - Oversee the BH component of BHCP. Recruit, hire, train, and supervise the BH Clinical Care Managers in support of CP contract requirements.

Senior RN Care Manager - Oversee the nursing component of BHCP. Recruit, hire, train, and supervise the RN Care Managers in support of CP contract requirements.

Clinical Care Manager - Provide and oversee integrated care coordination. Recruit, hire, train, and supervise Care Coordinators in support of CP contract requirements.

Care Coordinator - Participate in various trainings to provide integrated care coordination and management for individuals to be enrolled in the program in accordance with CP contract requirements.

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Staff training		15.5	$ 2,000.00
Total Training and Professional Development (Program Budget Line 3)			**$ 2,000.00**

Provide a description of each Training and Professional Development line item included in the table above:

Staff training - Training and orientation to be provided to the staff hired in the preparatory period, specifically for program onboarding and care management platform training.

All expenses are based on the 3.29 FTEs (approximately 15.5 employees; 3.29 FTEs total based on time of hire and based on percentage allocated to BH budget versus LTSS budget for shared staffing) anticipated to be hired during the preparatory period.

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
Staff travel	1188	6	0.43	$ 3,063.00
				$ -
				$ -
			Total Mileage	$ 3,063.00

Travel Expense Description	Cost
Total Mileage	$ 3,063.00
Parking and tolls	
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ 3,063.00**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

Staff Travel - staff mileage paid to staff for travel to meetings with affiliated partners, ACOs, and MCOs. Mileage is also paid to staff for travel to off-site trainings, conferences, etc. The staff mileage will be paid to all staff included in Row 1 as well as all staff included in the Infrastructure budget Row 12.

Row 5 - Equipment

Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost
Copier			$ 2,100.00
Total Equipment (Program Budget Line 5)			**$ 2,100.00**

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

There will be a central office floor model copier / printer which will be leased from Ricoh at a cost of $4,200/year. The prorated cost for the prepatory period is $2,100.

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Supplies			$ 1,553.00
Total Supplies (Program Budget Line 6)			**$ 1,553.00**

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Office Supplies: A cost analysis was completed to estimate the cost per item and needed inventory to stock the start up of this program including desktop items, e.g., staplers, paper clips, pens, etc. as well as supplies for printers, copiers.

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
			$ -
Total Contract Services (Program Budget Line 7)			**$ -**

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
Total Software Licensing (Program Budget Line 8)			

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Total Telecommunications (Program Budget Line 9)			

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent and Utilities	1550	$15	$ 23,250.00
Household Supplies			$ 1,578.00
			$ -
			$ -
			$ -
Total Occupancy (Program Budget Line 10)			**$ 24,828.00**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

Occupancy - Expenses related to office space needed for the BHCP program. These expenses include rent, utilities, as well as facility set-up expenses. Occupancy cost is estimated at 100 square feet per employee at $15 per square foot. The total cost for one month is estimated to be approximately $23,250 (15.5 FTEs x 100 square feet x $15 per square foot).

Household Supplies: A cost analysis was completed to estimate the cost per item and needed inventory to stock the start up of this program including cleaning supplies and sanitary items.

Row 11 - Other

	A	B
187	**Other Direct Expense Description**	**Cost**
188		
189		
190		
191		
192	**Total Other (Program Budget Line 11)**	
193		

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	**12.50%**	**$ 27,509.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

The Bridge of Central Massachusetts, Inc. calculates an indirect cost / administrative overhead for all of its programs at a rate of 12.5% of the subtotal of the program's expenses.

Community Partner Infrastructure Budget Report

		The Bridge of Central Massachusetts, Inc.						
Infrastructure Investment Funding		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
PMPM Infrastructure Rate			$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
Engaged Enrollees			1,703	1,703	1,938	2,648	3,089	
Estimated Infrastructure Funds			$ 1,192,100	$ 1,758,518	$ 1,197,451	$ 1,442,630	$ 1,456,031	**$ 7,046,731**
At- Risk Withhold Rate				25%	44%	63%	81%	
Withhold				$ 439,629	$ 526,879	$ 908,857	$ 1,179,385	**$ 3,054,750**
TOTAL MAXIMUM FUNDS AVAILABLE		$ 450,000	$ 1,192,100	$ 1,318,888	$ 670,573	$ 533,773	$ 276,646	**$ 4,441,980**
Infrastructure Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology								
1 **IT Staffing including Fringe**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
2 **Development Adaptation of EHR and/or Care Management System**		$ 75,000	$ -	$ -	$ -	$ -	$ -	**$ 75,000**
3 **Technology for Service Delivery**		$ 21,510	$ 109,777	$ -	$ -	$ -	$ -	**$ 131,287**
4 **Other Technology Expenses**		$ 1,770	$ -	$ -	$ -	$ -	$ -	**$ 1,770**
Total Technology		$ 98,280	$ 109,777	$ -	$ -	$ -	$ -	**$ 208,057**
Workforce Development								
5 **Workforce Development staffing including Fringe**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
6 **Recruitment Expenses**		$ 2,000	$ -	$ -	$ -	$ -	$ -	**$ 2,000**
7 **Training Expenses**		$ -	$ -		$ -	$ -	$ -	**$ -**
8 **Retention Expenses**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Total Workforce Development		$ 2,000	$ -	$ -	$ -	$ -	$ -	**$ 2,000**
Business Start Up Costs								
9 **Office Equipment (PBP & BP1 only)**		$ 6,803.00	$ 16,483.00					**$ 23,286**
10 **Office Furniture (PBP & BP1 only)**		$ 26,800.00	$ 105,489.00					**$ 132,289**
11 **Ramp-up Costs (PBP BP1, BP2 and BP3 only)**		$ 247,578	$ 641,152	$ -	$ -			**$ 888,730**
Total Business Start Up Costs		$ 281,181	$ 763,124	$ -	$ -			**$ 1,044,305**
Operational Infrastructure								
12 **Operation Staffing including Fringe**		$ 43,048	$ 93,474	$ 162,676	$ 168,932	$ 174,973	$ 176,913	**$ 820,016**
13 **Other Operational Expenses**		$ 3,000	$ 20,000	$ -	$ -		$ -	**$ 23,000**
Total Operational Infrastructure		$ 46,048	$ 113,474	$ 162,676	$ 168,932	$ 174,973	$ 176,913	**$ 843,016**
14 **Indirect Cost/Administrative Overhead Rate**	12.5%	$ 22,491	$ 43,153	$ 20,335	$ 21,117	$ 21,872	$ 22,114	**$ 151,081**
TOTAL INVESTMENTS		**$ 450,000**	**$ 1,029,528**	**$ 183,011**	**$ 190,049**	**$ 196,845**	**$ 199,027**	**$ 2,248,459**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
	Total Salary			$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Implentation of Care Management platform	$ 75,000.00
Total Development and Adaptation of EHR and Care Management System (Infrastructure Budget Line 2)	$ 75,000.00

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

The cost of the implementation of the care management platform was determined based on a formal quote received by the platform provider, eHana. The total cost of the platform is $200,000 and is being split between The Bridge of Central Massachusetts, Inc. (Lead agency for Behavioral Health Community Partner contract) and Alternatives Unlimited, Inc. (Lead agency for LTSS Community Partner contract).

Row 3 - Technology for Service Delivery

Description of Expense	Cost
Mobile technologies	$ 21,510.00
Total Technology for Service Delivery (Infrastructure Budget Line 3)	**$ 21,510.00**

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Each employee will be provided with a computer package customized to the needs of the positions.

Care Coordinators, because they will spend considerable time in the field, will receive a laptop with a hot spot. In order to easily link to the company systems, while in the office, they will have a docking station to hook into. The unit cost is approximately $1,460

for 12 units. These prices are based on a quote from Dell. Directors, Care Managers, and Referral Coordinators will receive a desktop workstation and monitor at a unit cost of approximately $1,140 for 3 units. The total prepatory period cost is $21,510.

Row 4 - Other Technology Expenses

Description of Expense	Cost
IT Staff (approx 70 hours x $25 per hour)	$ 1,770.00
Total Other Technology Expenses (Infrastructure Budget Line 4)	**$ 1,770.00**

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

IT staff time needed to configure laptops and stations, approximately 70 hours at $25 per hour.

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 6 - Recruitment Expenses

Description of Expense	Cost
Recruitment (job postings)	$ 2,000.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 2,000.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Job postings for positions to be hired in the preparatory period. The cost includes advertisement and recrutiment efforst in job

boards and media platforms.

Row 7 - Training Expenses

Description of Expense	Cost
Total Training Expenses (Infrastructure Budget Line 7)	**$ -**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Row 8 - Retention Expenses

Description of Expense	Cost
Total Retention Expenses (Infrastructure Budget Line 8)	

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Business Start Up Costs - Prep Budget Period

Row 9 - Office Equipment

Description of Expense	Cost
Office equipment	$ 6,803.00
Total Office Equipment (Infrastructure Budget Line 9)	**$ 6,803.00**

Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were determined:

Office equipment for staff hired in the preparatory period. Equipment consists of items purchased such as printers (approximately $150 each for 27 employees) and office phones (approximately $100 each for approximately 27 employees). The cost is based on approximately $250 per employee. In the prepatory period, there are 15.5 employees budgeted to be hired. Office equipment for an additional eleven to twelve employees will be purchased in the prepatory period to be configured for immediate use in Year One.

Row 10 - Office Furniture

Description of Expense	Cost
Office furniture	$ 26,800.00
Total Office Furniture (Infrastructure Budget Line 10)	**$ 26,800.00**

Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:

Office furniture for staff hired in the preparatory period. Furniture consists of items purchased such as desks (approximately $900 each for 15.5 employees), desk chairs (approximately $225 each for 15.5 employees), side chairs (approximately $215 each for 15.5 employees), file cabinets (approximately $250 each for 15.5 employees), a conference table (approximately $600), and conference room chairs (approximately $125 each for 6 chairs). The total cost is based on approximately $1,675 for each employee, There are 15.5 employees budgeted to be hired in the preparatory period.

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Quality Manager	$ 65,000.00	0.5	4	$ 10,724
Community Partnership Director	$ 95,000.00	0.5	6	$ 23,750
				$ -
				$ -
	Total Salary	1		$ 34,474
	Fringe rate	24.9%	Total Fringe	$ 8,574
			Total Program Staffing including Fringe (Infrastructure Budget Line 12)	**$ 43,048**

Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:

Quality Manager - CP quality activities, analysis, and reporting of indicators and outcomes for the BH CP program as required by the CP contract.

Community Partnership Director - Oversee the development of the CCHP/BH program and all its components, including overseeing staff hiring. Build relationships with agencies and provide support to the BH program and ensure the CP is meeting contract obligations.

The total cost of the Community Partnership Director and Referral Coordinator is being split between The Bridge of Central Massachusetts, Inc. - 50% (Lead agency for Behavioral Health Community Partner contract) and Alternatives Unlimited, Inc. (Lead Agency for LTSS Community Partner contract) - 50%.

Row 13 - Other Operational Expenses

Description of Expense	Cost
Consultation	$ 3,000.00
	$ -
	$ -

	Total Other Operational Expenses (Infrastructure Budget Line 13)	$ 3,000.00

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Consultation - Legal consultation provided for CCHP partnership and ACO/MCO agreements for the Behavioral Health Community

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**12.50%**	**$ 22,491.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

The Bridge of Central Massachusetts, Inc. calculates an indirect cost / administrative overhead for all of its programs at a rate of 12.5% of the subtotal of the program's expenses.

Community Partner Infrastructure Allocation Worksheet

	The Bridge of Central Massachusetts, Inc.						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 1,192,100	$ 1,318,888	$ 670,573	$ 533,773	$ 276,646	$ 4,441,980
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Affiliated Partner - The Bridge of Central MA, Inc.	$ 87,924	$ 50,497	$ -	$ -	$ -	$ -	$ 138,421
Affiliated Partner - Alternatives Unlimited, Inc.	$ 5,178	$ 30,738	$ -	$ -	$ -	$ -	$ 35,916
Affiliated Partner - LUK, Inc.	$ 2,589	$ 14,271	$ -	$ -	$ -	$ -	$ 16,860
Affiliated Partner - Venture Community Services	$ 2,589	$ 14,271	$ -	$ -	$ -	$ -	$ 16,860
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ 98,280	$ 109,777	$ -	$ -	$ -	$ -	$ 208,057
Workforce Development							
Affiliated Partner - The Bridge of Central MA, Inc.	$ 1,120	$ -	$ -	$ -	$ -	$ -	$ 1,120
Affiliated Partner - Alternatives Unlimited, Inc.	$ 440	$ -	$ -	$ -	$ -	$ -	$ 440
Affiliated Partner - LUK, Inc.	$ 220	$ -	$ -	$ -	$ -	$ -	$ 220
Affiliated Partner - Venture Community Services	$ 220	$ -	$ -	$ -	$ -	$ -	$ 220
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ 2,000	$ -	$ -	$ -	$ -	$ -	$ 2,000
Business Start Up Costs							
Affiliated Partner - The Bridge of Central MA, Inc.	$ 172,970	$ 218,657	$ -	$ -	$ -	$ -	$ 391,627
Affiliated Partner - Alternatives Unlimited, Inc.	$ 53,951	$ 133,094	$ -	$ -	$ -	$ -	$ 187,045
Affiliated Partner - LUK, Inc.	$ 27,130	$ 61,793	$ -	$ -	$ -	$ -	$ 88,923
Affiliated Partner - Venture Community Services	$ 27,130	$ 61,793	$ -	$ -	$ -	$ -	$ 88,923
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ 281,181	$ 475,337	$ -	$ -	$ -	$ -	$ 756,518
Operational Infrastructure							
Affiliated Partner - The Bridge of Central MA, Inc.	$ 46,048	$ 91,914	$ 162,676	$ 168,932	$ 174,973	$ 176,913	$ 821,456
Affiliated Partner - Alternatives Unlimited, Inc.	$ -	$ 21,560	$ -	$ -	$ -	$ -	$ 21,560
Affiliated Partner - LUK, Inc.	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Affiliated Partner - Venture Community Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ 46,048	$ 113,474	$ 162,676	$ 168,932	$ 174,973	$ 176,913	$ 843,016
TOTAL INVESTMENTS	$ 427,509	$ 698,588	$ 162,676	$ 168,932	$ 174,973	$ 176,913	$ 1,809,591

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Development and Adaptation of E.H.R/Care Management System	Configuration and implementation of CP IT platform	11/01/17	05/30/18	Configuration completed, implementation in progress	User Acceptance Testing completed			CP IT platform ready for Program Go-Live	CP IT platform is operational		
Technology	Development and Adaptation of E.H.R/Care Management System	Training of CP staff on Care Management platform	03/01/18	05/30/18	Training on CP platform in progress	Initial hires engaged in training			CP program staff trained on platform	Staff training complete		
Technology	Technology for Service Delivery	Identify and purchase computer packages for staff	12/01/17	05/31/18	Identify, purchase, and set up CP staff computer packages	Purchasing and set up in progress			Purchasing and set up completed and ready for program Go-Live	Computer systems operational		
Workforce Development	Workforce Development Staffing including Fringe	Recruitment and hiring of staff needed for program start-up	11/01/17	05/30/18	Initial hires identified and actively recruiting for remaining positions	Initial hires accepted job offers and are onboarding			CP Program staff in place for Go-Live	Remaining positions for Go-Live accepted job offers and are onboarding		
Workforce Development	Workforce Development Staffing including Fringe	Develop training curriculum	10/01/17	02/01/18	Goal completed	Training curriculum completed and ready for implementation			Curriculum completed	Curriculum completed		
Workforce Development	Workforce Development Staffing including Fringe	Training of staff on CP program curriculum	02/01/18	05/30/18	Training on CP curriculum	CP staff training in progress			CP staff training completed	Staff training completed		
Business Start Up Costs	Office Equipment	Purchase office equipment	12/01/17	12/31/18	Goal completed	Equipment purchased			Equipment in place and ready for Go-Live	Equipment functional		
Business Start Up Costs	Office Furniture	Purchase office furniture	12/01/17	12/31/18	Goal completed	Furniture purchased			Furniture in place and ready for Go-Live	Furniture in place		
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Other Operational Expenses	Contract with consultant for CP administration	10/01/17	10/01/17	Goal completed	Consultant working with CP			Consultant working with CP	Consultant working with CP		
Operational Infrastructure	Other Operational Expenses	Office space for CP program	10/01/17	05/01/18	Space / Site identified	Purchase or lease agreements being executed			CP Program site occupied and ready for Go-Live	CP program staff working out of CP program site		

BH Community Partner - Staffing Model

The Bridge of Central Massachusetts, Inc.

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	1703	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	0.81	*Total management oversight of BH CP*
3	Medical Director	0.1	*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs	2.27	
5	Clinical Care Managers (RN)	2.41	*Do not include FTEs listed in line 4*
6	Clinical Care Managers (LPHA)	2.37	*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders	2	*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff		*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	37.84	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)		*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists	0.81	
12	Administrative Support	1.62	
13			
14			
	Total FTE	50.23	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1:300	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	1:8	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff: The Clinical Care Managers (RN) and (LPHA) will directly supervise the Care Coordinator staff. Clinical Care Managers will either be a Licensed Clinician or an RN.

Section 7.3 Initial DSRIP Participation Plan

A. Executive Summary

1. Goals, Challenges, and Proposed Solutions

The Bridge of Central Massachusetts, Inc. (The Bridge) as the Lead Agency with its Affiliated Partners and Material Sub Contractors, including, but not limited to, Alternatives Unlimited, Inc. (Alternatives), LUK Crisis Center, Inc. (LUK) and Venture Community Partners (Venture) as Affiliated Partners and AdCare as a Material Subcontractor ("CCHP/BH"), represent an ideal collective of premier human service organizations in Central Massachusetts which employ evidence-based practices to deliver both Behavioral Health (BH) and Long-Term Services and Supports (LTSS). We serve individuals with MassHealth coverage as well as other State EOHHS funded consumers. CCHP/BH partners provide trauma-informed, best practice services to individuals with Serious Mental Illness (SMI) and Substance Use Disorders (SUD) who present with a variety of medical, physical and developmental disabilities.

Our unique application to EOHHS provides fully integrated BH and LTSS CP services to those individuals who require them, while also providing services to individuals who require either BH or LTSS services individually. This RFR submission is specifically to participate as a certified BH Community Partner (BH CP). Collectively, we have unprecedented breadth and depth providing services that closely resemble the same BH CP services that the State is now procuring.

An important aspect to our approach is the inclusion of specialized services for individuals with SUD through AdCare, a Material Subcontractor on this RFR submission. In addition to contracting with AdCare to lead the delivery of BH CP support services to individuals with SUD, we will provide "Recovery Support Navigators" with specialized expertise in supporting this population.

Our organizations are deeply connected with providers, Accountable Care Organization (ACOs) and other community-based organizations (CBOs) within our service area. Given the depth and breadth of existing provider relationships, we are already speaking with ACOs about developing unified assessments and treatment plans to play a meaningful role in integrating care.

Goals. CCHP/BH goals align closely with the State's goals to:

- Support Enrollees with high BH needs to help them navigate the delivery system
- Improve the Enrollee experience by holistically engaging Enrollees with high BH needs with services that strengthen, enhance and diversify access for individuals and families we serve
- Assist individuals in integrating into the community through attaining valued community roles, active membership in local organizations and meaningful relationships
- Incorporate an enhanced data-driven, evidence-based decision-making process currently used in our organizations today to guide clinical and administrative decisions
- Support community first values, SAMHSA recovery principles, and culturally competent care delivery by adopting evidenced- based, best practices

- Collaborate with ACOs, MCOs, CPs, and community organizations to integrate care and address the social determinants of health

Challenges and Solutions. Challenges and solutions associated with meeting the State's BH CP Contract requirements:

Challenges	Solutions
Support true care integration	Utilize a single system that supports data integration among Affiliated Partners, ACOs and others Educate Enrollees and providers re: integration Leverage existing relationships
Connect Enrollees to social service agencies and community organizations to address social determinants of health	Leverage the close relationships we have developed with local organizations throughout the community that serve Enrollees
Develop Information Technology (IT) tools to share regarding care across the full continuum of medical and psychosocial support services	Identify and develop IT solutions that support information connectivity and sharing of information, leveraging BH, existing infrastructure and resources.

2. Anticipated Number of Enrollees

CCHP/BH organizations currently serve an estimated 1,430 BH CP Eligible Enrollees. CCHP/BH will have the capacity to serve approximately 1,700 BH CP Eligible individuals, within the proposed Service Region, during the first year of service delivery. We will develop the ability to serve 3,000 or more individuals during over the course of the contract.

3. Service Areas

CCHP/BH proposes to serve MassHealth Enrollees in all the Central Region, excluding towns in the Waltham service area.

4. Plans to Operationalize the CP Program

These changes in hiring schedules are reflected in the revised budgets and budget narrative.

To operationalize the CP program, CCHP/BH will engage in the following crucial implementation activities, based on time frames indicated below:

Activity	Timeline (Start)
Execute contractual agreements w/MCOs and ACOs	Upon Selection
Develop and implement Contractor Governance structure	Upon Selection
Identify, hire and recruit staff	Winter 2018
Orient and train staff regarding Contract requirements	Spring 2018
Develop the process to accept Assigned enrollees from EOHHS and all related processes and work flows	Upon Selection
Identify and develop general operational business functions	Upon Selection

Create and implement a Consumer Advisory Board	Winter 2018
Develop, distribute and implement a Conflict of Interest policy	Upon Selection
Finalize policies that describe CP Support protocols	Upon Selection
Develop and implement a comprehensive QM/QI strategy	Within 90 days of Selection
Develop IT capabilities	Upon Selection

B. Supporting Populations and Community Engagement

1. Connections to the Community

CCHP/BH, with over 40 years of experience, engages community-based organizations (CBOs) to integrate BH, LTSS and physical health, and to address social determinants of health.

CBOs: Active engagement with the United Way organizations in each of our Service Areas, Youth Connect, City of Worcester DPH, Coalition for a Health Greater Worcester, the Spanish American Center, CENTRO, the YWCA, Worcester Community Action Council, Community Health Link, and other Federally Qualified Health Centers.

Advocacy groups: Collaboration with Parent-Professional Advocacy League, National Alliance on Mental Illness, Kiva Center of the Central MA Recovery Learning Community, Massachusetts Organization for Addition Recovery (MOAR), Everyday Miracles Peer Recovery Support Center, and the SHINE Initiative, promoting best practices in behavioral health (BH) delivery.

BH providers: Care coordination with primary care physicians (PCPs) and community-based BH providers. Enrollee referral to Community Health link, Riverside Community Care, CHL Lipton Center, UMass Memorial and affiliates, Heywood Hospital, The Griswald Center, The Wells Center, Harrington Hospital, South Bay Intervention, Justice Resource Center, Advocates, Inc., South Middlesex Opportunity Council, Clinical and Support Options and Center for Human Development.

Housing/shelter providers: Collaboration with the City of Worcester through an Emergency Solutions Grant to provide support for homeless individuals with mental health and substance use challenges; address homelessness through participation on the Worcester County Continuum of Care committee and partnering with the Central Massachusetts Housing Alliance.

Social service organizations: Coordination with, and referral of Enrollees to, Worcester Community Action Council (WCAC), Employment Options and Genesis Clubhouses, Montachusett Opportunity Council, Our Father's House, Gardner Community Action Committee, Friendly House, and Daybreak for emergency housing; and South Middlesex Opportunity Council.

2. How We Will Grow our Connections to the Community

CCHP/BH will leverage and build on existing relationships in the community.

Participation in community health needs assessments: The Bridge has worked closely with the City's Department of Public Health on MH and SUD components of the Community Health Improvement Plan and will continue to lead workgroups and implement strategies.

Engagement to grow community connections: The Bridge serves on the City of Worcester's Quality of Life Task Force and participates on a committee to address the City's major opioid crisis. The Bridge and our Affiliated Partners are involved in a wide variety of community-based initiatives, many of which are aimed at addressing the opioid crisis.

The Bridge and LUK are members of the Worcester County Continuum of Care committee and partner with the Central MA Housing Alliance to address homelessness in the region.

The Bridge enjoys strong relationships with many other community-based organizations. For example, over the past two years the Bridge has trained the entire Worcester Police Department on mental health interventions as part of the Crisis Intervention Team and has worked with multiple school systems throughout the region on suicide prevention, social emotional learning, and policy changes in schools in support of LGBTQ youth served by our Safe Homes program. The Bridge is also the founding member of a new Provider Alliance convened by Clark University to address health equity in a culturally responsive manner.

Alternatives is recognized nationally for its work with community organizations on social connectedness. The agency has developed a comprehensive curriculum that teaches staff and individuals served how to make deeper community connections and how to become members of local community organizations. In addition to training, the agency has developed a number of non-traditional clubs and activities that help people make connections. The agency performed a baseline survey of over 1000 members and has administered two bi-annual re-surveys that demonstrate a 15% improvement in social connectedness.

LUK maintains strong connections to community organizations including coordinating 11 Intensive Learning Communities for 50 behavioral health agencies and training 500 clinicians and
100 paraprofessionals in Evidence-based Trauma treatment. LUK also developed Trauma Informed Leadership Teams, bringing child welfare and community partners together to coordinate care for the most vulnerable children and families impacted by trauma.

Link to Business Plan: CCHP/BH will incorporate relationship development as an essential aspect of our business plan, seeking to increase the number and depth of relationships with community-based organizations that support the psychosocial needs of our Enrollees.

3. Plans to Ensure Staff is Informed of Community Resources

Staff training: We will organize and conduct on-going educational sessions for staff during work hours to support collaboration with community organizations including, community resource information for new staff, periodic staff conferences, invited community guest speakers, training on evidence-based and best-practices, and participation in community events.

Interdisciplinary Care Team (ICT) meetings: The ICT will review Enrollee needs and identify which community-based resources can best support the Enrollee. If Enrollee needs and opinions change, CCHP/BH will engage additional community-based agencies and providers as needed.

C. Community Partner Supports and Activities

1. Outreach and Active Engagement

a. Strategies for Outreaching to and Engaging with Assigned Enrollees Who Are Homeless and Hard to Reach

CCHP/BH subscribes to the Substance Abuse and Mental Health Service Administration's (SAMSHA) philosophy and approach to locate, outreach and engage Assigned Enrollees who have not otherwise been engaged in services. This philosophy begins with our understanding of the Enrollee's current relationships with a BH provider and the importance of meeting the Enrollee's basic needs. As we initiate contact with the Enrollee, we build rapport and trust, thereby increasing our ability to connect Enrollees to services without making them feel uncomfortable, judged or threatened.

Key outreach strategies follow.

Today, CCHP/BH organizations meet consumers at any available location in the community where they are personally comfortable, which may include but not be limited to their home, neighborhood locations, PCP and other medical and behavioral health provider offices, motels, shelters, or congregate meal sites among other locales. CCHP/BH will continue this practice. We seek to truly connect with the Enrollee and build trust, regardless of where we physically meet. We feel strongly that asking the Enrollee to select the location that would be most comfortable for them is an important step toward building the Enrollee's trust and confidence in our service delivery.

Our organization makes the process of building a relationship with the Enrollee as primary, and does so by being highly respectful toward Enrollees and their families. We seek to create a safe, friendly environment that respects their privacy. Upon meeting with the Enrollee, we will obtain their consent to participate and then begin to assess and meet his or her basic needs.

We hire highly qualified, culturally-competent individuals who are trained in evidence-based and best practices such as motivational interviewing, wraparound, psychiatric rehabilitation, and the use of peer supports to engage Enrollees. Our staff are very skilled at interacting with individuals who have SMI and SUD diagnoses. Furthermore, we hire staff who have lived experience, are in recovery and/or who are experienced at serving the target population and understand their needs and preferences, well beyond cultural and linguistic needs. Additionally, we provide training on strategies for mitigating the effects of symptoms that impact engagement such as paranoia, disorganized thinking and behavior, delusions, and hallucinations.

Our primary strategies to outreach Enrollees, including individuals who are homeless, reflect the philosophy and strategies described above. For individuals who are homeless, our efforts

notably include direct community outreach in areas where homeless individuals congregate and live, including shelters, food pantries and parks. An example of our success in this area was highlighted in 2016 when The Bridge was awarded a contract to work with 11 chronically homeless individuals diagnosed with SMI and SUD. In a four-month time period we successfully engaged and housed all 11 participants.

Engagement Process. CCHP/BH's Care Coordination (for individuals with primary SMI issues) or Recovery Support Navigator (for individuals with primary SUD needs) contact will be responsible for engaging individuals in BH CP services. CCHP/BH partners will employ Care Coordinators and Recovery Support Navigators to outreach and connect with Enrollees to schedule in-person contact. We will attempt to make at least one Outreach activity to each Assigned Enrollee within 30 days of Assignment and, to achieve a face-to-face visit within 3 calendar months of Assignment.

If appropriate, CCHP/BH may make the first in-person contact during an acute care event at a local hospital, taking care to ensure that the Enrollee is agreeable. In this manner, CCHP/BH partners will proactively participate in the Enrollee's transition of care at the outset of their enrollment.

Using motivational interviewing techniques, a CCHP/BH Care Coordinator or Recovery Support Navigator will explain how BH CP services can help them achieve their goals and mitigate frustrations with the delivery system. Care Coordinators will explain that the program is intended to help enrollees overcome barriers to care, build a network of support and introduce ways to participate in the community for improved wellbeing.

During the first in-person contact, CCHP/BH staff will employ motivational interviewing to understand the Enrollee's health status, their needs and preferences and, their aspirations and/or frustrations with barriers to care delivery that require attention. The initial meeting will further allow CCHP/BH staff to assess the Enrollee's needs and preferences in their primary preferred language with attention to cultural beliefs. Individuals who choose not to enroll will be provided with contact information should they choose to enroll later, and will be asked if periodic outreach from a Care Coordinator or Recovery Support Navigator is acceptable. We will also explain the anticipated frequency and type of interaction available for CP service delivery.

Before the end of the initial visit, CCHP/BH staff will provide individuals that choose to receive BH CP services with introductory material including information regarding the benefits, design and purpose of CP supports. Such information will be offered in written and verbal formats and, will be available to Enrollees in their primary preferred language for the most commonly spoken languages among the population served. We will provide information regarding the BH CP service delivery process with a focus on helping the Enrollee understand how to engage with our organization. For example, we will provide Enrollees with detailed information regarding how to reach their primary Care Coordinator. Our Care Coordinator or Recovery Support Navigator will explain that the Enrollee can opt out of receiving CP services at any time. Enrollees will also be able to request assignment to a different staff member within our organization or assignment to a different BH CP organization at any point in time. We will also

provide information regarding how to reach CCHP/BH's web site and Consumer Advisory Board, and a Care Coordinator or Recovery Support Navigator.

Where possible and desired by the Enrollee, the individual who performs the initial contact and assessment will serve as the Care Coordinator on an ongoing basis and will take a leadership role in delivering services as part of our BH CP team. If the Enrollee prefers a different Care Coordinator or Recovery Support Navigator, another staff member from the CCHP/BH will be assigned to that individual, based on their preferences and feedback.

CCHP/BH has initiated conversations with potential ACOs that support and enable our ability to obtain notification from a patient advocate regarding an Enrollees' admission or ED registration at local area hospitals. The Bridge and its' Affiliated Partners will work with hospital-based advocates directly (as appropriate and determined by the hospital) when the Enrollee is in the ED, or inpatient. In collaboration with CCHP/BH, Care Coordinators or Recovery Support Navigators, we will partner with hospital based case managers to improve notification to the BH CP, integration, and consistency of care plan implementation while eliminating duplication of effort and confusion for Enrollees.

The success of this program is predicated on sustained and trusting relationships between Enrollees and our Care Coordinators, which are established and cultivated through regular face to-face contact. Given our extensive experience with the population, we are aware that multiple in-person contacts may be required before an individual chooses to engage with their Care Coordinator. Care Coordinators will attempt to schedule an initial appointment telephonically and schedule to meet with the Enrollee in the community and will adhere to Enrollee preference regarding where and when to meet with Enrollees. In addition, the Care Coordinator or Recovery Support Navigator will seek Enrollee input regarding their desire to involve a family member or care giver (or other individual) in their care.

b. Strategies for Outreaching to and Engaging with Assigned Enrollees with Substance Use Disorders (SUD)

We tailor our approach for individuals with an SUD diagnosis to the Enrollee's readiness to engage in a recovery process and take any positive step towards harm reduction by reducing use of substances and achieving abstinence. For individuals who are seeking treatment, our approach will resemble our approach to outreach and engagement described above for individuals with BH needs. Our Material Subcontractor, AdCare, employs motivational coaching and interviewing to engage clients in the assessment, treatment planning and treatment implementation. We will assign staff with expertise in treating SUDs, known as Recovery Support Navigators. We will also hire and deploy Peer Supports with lived experience where appropriate, to support Enrollees with SUD diagnoses. Other specific strategies to outreach and engage individuals with SUDs follow.

A Recovery Support Navigator will meet the Enrollee at any location in the community where they are personally comfortable, which may include but not be limited to neighborhood locations, motels, shelters, or congregate meal sites among other locations. We seek to truly connect with the Enrollee and build trust, regardless of where we physically meet.

If appropriate, CCHP/BH may make the first in-person contact during an acute care event at a local hospital or other levels of acute care to ensure that the Enrollee is comfortable. CCHP/BH will strengthen existing relationships with agencies providing acute levels of addiction care including but not limited to acute treatment services (i.e., detoxification); clinical stabilization services; and transitional support services. In addition, existing collaborations will be strengthened with adult residential programs and Recovery Homes. This is especially critical for individuals struggling with addiction, as discharge from a controlled environment, in which the person does not have access to substances, to life in the community places the person at a higher risk for a lapse or relapse resulting in a setback on his/her road to recovery. In this manner, CCHP/BH partners will proactively participate in the Enrollee's transition of care at the outset of their enrollment.

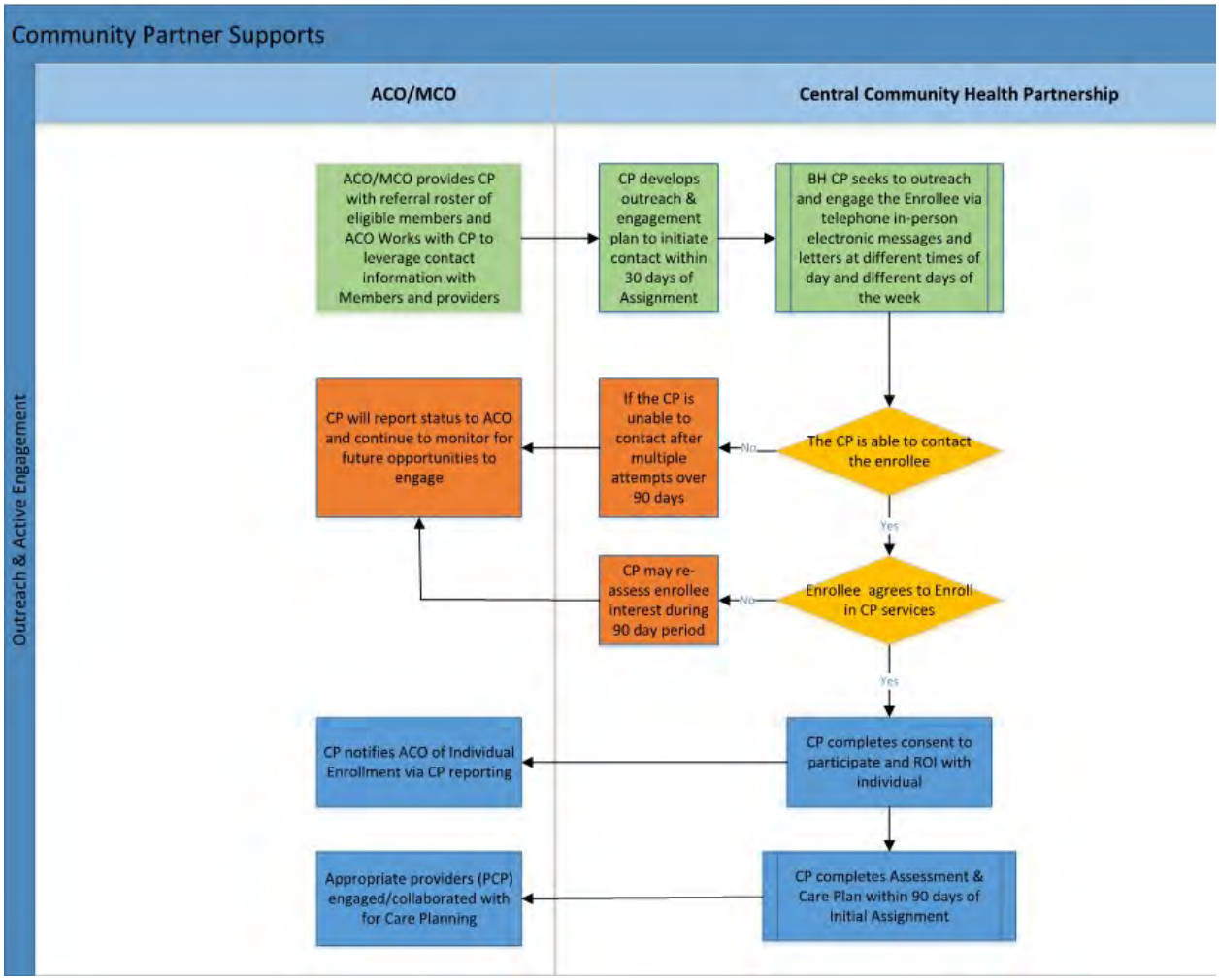
In addition to utilizing acute care events as an entry point for engaging with persons with SUDs, other community connections will be utilized. For persons in recovery a trusting relationship with an existing provider or social support (e.g., primary care physician, outpatient therapist, sponsor) is critical. If enrollees are comfortable and consent, CCHP/BH Recovery Support Navigators will facilitate "warm hand offs" to other providers. These meetings may occur in doctor's offices, outpatient clinics, or community-based recovery support meetings (e.g., AA, NA). In this way staff are truly meeting enrollees where they are in order to enhance effective engagement in care coordination activities.

CCHP/BH will emphasize the relationship development process as primary in the CP service delivery process, for individuals with SUD and other diagnoses, as described above. As is the case today, our staff, using motivational interviewing strategies, will be highly respectful toward Enrollees and their families regardless of the struggles associated with their diagnoses. We will seek to create a safe, friendly environment in which to meet without judgement regarding substance use while respecting the Enrollee's right to privacy, and with their consent. We will immediately attempt to assess and meet Enrollee's basic needs to gain the Enrollee's trust and, to provide immediate and tangible support as needed. We will seek to support housing, food and safety as basic needs from the outset.

c. Process to Obtain and Document Assigned Enrollee's Agreement to Participate in CP Supports Through a Participation Form

At the initial visit, prior to the assessment, each Enrollee will be asked to sign a Consent to Participate and Releases of Information with any other identified providers. We will train our staff carefully to explain the purpose of the participation form to the Enrollee and confirm their desire to participate in BH CP services. We will further explain the concept of Protected Information (PI) and how we intend to gather, store, utilize and protect any information provided by the Enrollee. CCHP/BH's Care Coordinator or Recovery Support Navigator will explicitly inform the Enrollee, in their primary preferred language in a manner that the Enrollee can fully comprehend, our need to obtain the Enrollee's written authorization to use and disclose PI as necessary to provide quality BH CP support services.

Following receipt of the Consent to Participate form, we will formally assign a CCHP/BH Care Coordinator or Recovery Support Navigator within five business days of receipt of the signed participation form. The CCHP/BH Care Coordinator or Recovery Support Navigator will serve as the Enrollee's single point of contact and conduct engagement and enrollment activities. A copy of the form will be maintained in the Enrollee's record. The process to obtain and document the Assigned Enrollee's agreement to participate in CP Supports through a participation form is as follows:



2. Comprehensive Assessment and Person-Centered Treatment Planning

a. Process for Conducting Comprehensive Assessments

We place the Enrollee at the center of the Assessment and treatment planning process, constantly engaging them to identify their needs, priorities and preferences. For the BH CP Comprehensive Assessment, CCHP/BH will utilize the Massachusetts Standardized Documentation Project (MSDP) tool.

Our process begins with a review of medical records and any available documentation regarding the Enrollee's needs and condition by a Care Coordinator or Recovery Support Navigator.

Specifically, CCHP/BH staff will review the Assigned Enrollee's medical history, medical needs and medications and summarizes these needs.

CCHP/BH organizations seek to leverage any information already collected by the Enrollee's MCO or Accountable Care Organization (ACO). We believe this is important to maintaining an Enrollee centered, efficient process that minimizes duplication and demands on the Enrollee. We are already engaged in conversations with ACO and MCOs in our geographic area regarding Information Technology (IT) strategies to leverage and share data to avoid duplication of effort

or strain on the Enrollee. Ultimately CCHP/BH organizations seek to develop a single integrated assessment with the Enrollee's ACO or MCO, building on information already obtained from the Enrollee. The same principle applies to the Person-Centered Treatment Plan (PCPT).

The ACO will gather Initial and Comprehensive Assessment data to evaluate issues that shape care management services and CCHP/BH partners will focus on gathering information to thoroughly plan the delivery of BH services for our Enrollees.

With the Enrollee's permission, we hope to establish connectivity to share relevant and available data from the Enrollee's ACO or MCO and incorporate that data within the MDSP Assessment. Our staff will meet with the Enrollee and administer the complete Assessment, attempting to avoid duplication in the questions asked, unless current information is needed. CCHP/BH's Care Coordinators and Recovery Support Navigators will employ motivational interviewing techniques that specifically assess the Enrollee's immediate care needs, current services, personal and familial medical history, medications, health communications skills, etc. as part of the Assessment.

Beyond collaborating on the Comprehensive Assessment process, CCHP/BH staff plan to participate on each Enrollee's ACO ICT, and will play a critical role in the formation and convening of the ICT for all individuals who are BH CP Eligible. If the Enrollee has an existing relationship with a PCP, state agency care/case managers or other treatment providers, we will engage these key individuals in the Assessment and the PCTP process as described below. Following the completion of the Comprehensive Assessment by the CHCP/BH Care Team, we will communicate the results of the Assessment to the team and jointly determine implications for on-going care planning. Consistent with EOHHS requirements, a qualified CCHP/BH nurse will review each assessment prior to its completion.

CCHP/BH will use a combination of the Massachusetts Standardized Data Project (MSDP) forms to perform Comprehensive Assessments for BH CP Eligible individuals. We agree to meet all EOHHS requirements pertaining to mandatory data elements mandated in the Model Contract. We will select appropriate forms based on adult, SMI or SUD status. Our goal is to maximize person-centeredness, minimize duplication and maximize efficiency. We plan to review and discuss the MSDP tools, included as Attachment 7.3.C.2.A to this RFR submission with local ACOs, prior to sharing our final selection of forms with EOHHS. The attached MSDP forms include: a Comprehensive Assessment for Adults, a Physical Health Assessment (in the event that such information is not available from the ACO); and, an Addictive Behavior and Substance Use History Addendum.

b. Process for Conducting Person-Centered Treatment Plans

1) Planned processes for developing the Person-Centered Treatment Plan, including ensuring the Assigned Enrollee participates in the process. After the Comprehensive Assessment is completed, CCHP/BH's Care Coordinator or Recovery Support Navigator will work with each Enrollee, placing the Enrollee's opinion first and foremost. We will use available data, in combination with Enrollee input to develop a PCTP. CCHP's Care Coordinator or Recovery

Support Navigator will engage the individual through person-centered planning strategies as a foundational element of the PCPT.

CCHP/BH will conduct a collaborative conversation, directed by the Enrollee, in partnership with providers and natural supports to formulate the care plan. In this process, CCHP/BH will employ shared decision-making, understanding and consideration of cultural differences and a recovery orientation. CCHP/BH staff will utilize tools and strategies to help the individual identify both short-term and long-term meaningful and personalized goals. Key components of CCHP/BH's process include: pre-meeting activities; assessment; treatment planning; care plan implementation; and care plan review and revision.

CCHP/BH partners plan to deliver integrated BH care in collaboration with our ACO and MCO partners in our service area. With the Enrollee's consent, we will seek to participate in ACO or MCO ICT meetings and/or will invite the Enrollee's ACO/MCO to any care planning meetings that CHCP/BH organizations schedule. CCHP/BH will play a leadership role in discussing Enrollee needs in an integrated manner, rather than requiring the Enrollee to attend separate meetings with their ACO or MCO and CCHP/BH. If the Enrollee prefers a separate meeting specifically to discuss their BH needs, we will offer a session with the Enrollee's Care Coordinator and other BH CP Team members as requested.

CCHP/BH's PCTP will include but not be limited to: Enrollee goals and objectives, specific action steps to achieve goals, method for tracking goal progress, referral needs to obtain care and services, educational needs, and any other necessary information. PCTPs may also include a crisis plan, especially for individuals with BH needs with a history of crisis service utilization. Our Material Subcontractor, AdCare, currently uses a person-centered approach in developing treatment plans to engage individuals with a range of SUD needs and will extend their expertise to CCHP/BH Enrollees.

CCHP/BH's Care Coordinator or Recovery Support Navigator will review the PCTP and other information with the Enrollee including but not limited to, the Enrollee's right to appeal any denial, termination, suspension or reduction in services or any change in providers, services, treatment recommendations or medications included in the PCTP. Policies and procedures will include steps to inform each Enrollee of their right to approve the PCTP and the mechanism to signify that Enrollee PCTP approval has been given. Upon Enrollee approval of the PCTP, the BH CP will provide the Enrollee with a copy, which we will also share with the ACO.

2) Planned processes for documenting the Person-Centered Treatment Plan. CCHP/BH plans to document the Enrollee's PCPT in our electronic medical record/ centralized care management platform.

3) Planned processes for updating the Person-Centered Treatment Plan. CCHP/BH will update the PCTP in collaboration with the Enrollee, their family members/caregiver, the ACO or MCO and other key stakeholders identified by the Enrollee. Our Care Coordinators and Recovery Support Navigators will update treatment plans at any major change in the Enrollee's condition (e. g. loss of housing, loss of informal caregiver, BH crisis, new BH diagnosis, BH or medical hospitalization, change in health status, multiple

ED visits), progress toward treatment goals, a decline in functioning, or transition between levels of care. If the Enrollee's quality of life is not improving or the Enrollee feels that the plan needs an update, we will also update the PCPT. CCHP/BH will seek to obtain sign-off from the PCP who will receive a copy of the PCTP upon completion. CCHP/BH will coordinate care with the PCP based on the Plan.

The CCHP/BH Care Coordinator or Recovery Support Navigator will share PCTP updates with the Care Team within the Enrollee's ACO or their MCO and, internally. Recognizing that Enrollee's needs are fluid, our Care Coordinator or Recovery Support Navigator will review the PCTP and the Enrollee's progress during each interaction and inform key stakeholders as necessary and appropriate while respecting Enrollee privacy and wishes.

CCHP/BH will complete an annual re-assessment that includes, but will not be limited to: updates that review past progress toward goals, health status, future goals, monitoring of compliance with the PCTP, recommended follow-up and a complete update to the PCTP. Each time a reassessment occurs, or if the PCTP changes because of a review, we will update and distribute the PCTP appropriately. A reassessment and update to the PCTP will be performed at least every six months and following a change in Enrollee status that is self-limiting, impacts their health status and requires a review.

We will implement a process that is consistent with the creation of the original PCTP where the Enrollee and the PCP approve the Plan prior to implementation. We will further review and provide a copy of the Plan to the Enrollee and the PCP upon completion.

4) Planned process for ensuring the Assigned Enrollee and the Assigned Enrollee's PCP or PCP

Designee approve the Person-Centered Treatment Plan. Ideally, the PCTP will be developed by CCHP/BH staff with input from the Enrollee's PCP, ACO-PP or MCO ICT. The Care Coordinator will share the PCTP with the Assigned Enrollee and the Enrollee's PCP to obtain sign-off following a complete review by the registered nurse and/or Clinical Care Manager.

3. Care Coordination and Care Management

a. Identifying all Stakeholders Involved in an Enrollee's Care

CCHP/BH will identify all stakeholders involved in the Enrollee's care through multiple methods. First and foremost, we will ask the Enrollee which individuals they most want involved in their care team and care delivery efforts. Once the Enrollee has been consulted regarding those individuals who they believe are critical to care management and planning efforts, our Care Coordinator will contact the individuals' PCP, involved State agencies and community-based organizations who are involved in the Enrollee's care. The Care Coordinator or Recovery Support Navigator will also contact the Enrollee's ACO or MCO to determine what care management efforts are already underway so that care is fully integrated and coordinated without waste or duplication of efforts. Our Material Subcontractor, AdCare, has expertise in care coordination and recovery coaching for SUD and overdose victims. CCHP/BH partners will assemble a care team that includes, but will not be limited to: The Enrollee, the PCP, the CCHP/BH Clinical Care Manager, the Enrollees' Care Coordinator or Recovery Support

Navigator, their BH clinician and others as appropriate (e. g. family, caregivers, advocates, state agency staff or other care managers).

b. Exchanging Information with Such Stakeholders

In collaboration with potential ACOs, in our service areas, CCHP/BH will develop a process to share information securely in an electronic format with any stakeholders that are also connected with the ACO. For other stakeholders, we will develop a process for securely sharing information using a standardized format.

c. Identifying and Organizing Members of the Enrollee' Care Team

A description of how we will identify members of each Enrollee's care team is described above in Section C.3.a. of this RFR submission. As already stated, CCHP/BH staff will participate in the ACO or MCO's ICT whenever possible. Otherwise, CCHP/BH will facilitate a meeting of the Enrollee's full ICT to participate in the development and implementation of a fully integrated person-centered assessment and care planning process for each individual Assigned to CCHP/BH.

d. Ensuring Effective Ongoing Communication Across Stakeholders

CCHP/BH will ensure effective ongoing communication across stakeholders through multiple means. First, we will maintain close contact with the Enrollee and will further ensure that their needs and preferences are met. In addition, we will maintain close and collaborative contact with the Enrollees' PCP and key agency and community-based caregivers to ensure coordination and integration. While we plan to participate in, or hold, an ICT meeting to initially create a plan to meet the Enrollee's needs, we will reach out to key stakeholders telephonically as needed and initiate meetings when appropriate and necessary. We will collaborate with providers and stakeholders to develop a joint case rounds process to discuss ways to support Enrollees with complex needs, such as those with BH and LTSS needs.

Key to meeting Enrollee's needs, we will communicate closely with the Enrollee and family/informal caregiver, the Enrollee's PCP, specialist and other providers to communicate the PCTP as part of the overall ICT. We will further promote good medical care by coordinating the provision of medical, prenatal, outpatient behavioral health and preventative care reminders with the ACO or MCO. Care Coordinators and Recovery Support Navigators will assist Enrollees in scheduling both medical and BH appointments and, will conduct follow-up, in collaboration with the ACO or MCO, to ensure that appointments are kept and, that the Enrollee does not require additional supports.

4. Care Transitions

CCHP/BH staff are aware that transitions of care represent an important opportunity to ensure quality, Enrollee satisfaction and cost-effectiveness of care delivery, based on the extensive work we do today to support transitions of care. We will deliver transitional services that support the

Enrollee's chosen living situation; and, avoid or decrease unnecessary Emergency Department (ED) visits or hospitalizations. CCHP/BH's goal is to support the Enrollee's ability to live successfully in the community, in the setting of their choice.

We will participate, in collaboration with the ACO or MCO and other providers, in transition planning prior to an inpatient discharge. We will maintain strong relationships with the ACO or MCO, participate in discharge planning meetings and follow-up with hospitalized Enrollees through a face-to-face visit that will occur as quickly as possible following discharge. We feel strongly that visits to Enrollees who were recently hospitalized must be coordinated with the ACO or MCO so as not to overwhelm the Enrollee. Our Material Subcontractor, AdCare, offers robust transitions of care with immediate enrollment into outpatient treatment, post inpatient admission. AdCare also provides expertise in transitions from intensive outpatient treatment to less intensive services such as Structured Early Recovery.

As part of the transition process, we will update the PCTP and will coordinate clinical and support services as needed. We will further assist the Enrollee to access additional supports from providers (with warm hand-offs as needed and appropriate) and follow-up to ensure that the Enrollee attends the appointment. Where Enrollees miss appointments, we will offer transportation assistance to decrease barriers to care delivery.

Throughout the transition, the Care Coordinator or Recovery Support Navigator will share information on the discharge plan and the Enrollee's status with the ACO or MCO, and other providers. CCHP/BH currently has relationships with organizations that have applied to be ACOs that will be administering this program and have begun discussions to refine processes for sharing information with these organizations. For example, we have initiated conversations with potential ACOs that support and enable our ability to obtain notification from a patient advocate regarding an Enrollees' admission or ED registration at local area hospitals, using the State's event notification system. We will develop similar processes for sharing information with other ACOs in our service areas. Similarly, we will collaborate with providers to develop protocols for securely exchanging information to promote continuity of care for enrollees during care transitions.

5. Medication Reconciliation

CCHP/BH adheres to evidence-based and best practices in all aspects of care management, transition planning and medication administration. Following is a description of how we will support individuals in activities associated with Medication Reconciliation.

Our registered nurse, a participant on each Enrollee's ICT, will perform a medication reconciliation as part of transition planning within three days of discharge. As part of that process, CCHP/BH will contact the Enrollee's PCP to verify medication orders. We will verify that all prescriptions are accessible (including over-the-counter drugs) and were filled appropriately. CCHP/BH will help remove barriers to prescription compliance when needed by the Enrollee. The CCHP/BH nurse will directly collaborate with the Enrollee and Care Coordinator or Recovery Support Navigator to monitor medication needs and changes.

The Care Coordinator or Recovery Support Navigator and the registered nurse of the team will identify additional supports to assist the Enrollee with taking their medications appropriately if needed, such as the use of pill planners and visual and/or auditory prompting techniques. If the Enrollee is in a Medication Assistance Program (MAP) the Care Coordinator or Recovery Support Navigator will work with the Enrollee's PCP to update the medication order forms with the MAP provider. Our nurse will be available to review the Enrollee's medication forms and educate the Care Coordinator or Recovery Support Navigator and Enrollee and/or their family or informal support, as needed, to make sure the Enrollee understands, and is willing to follow, their medication regimen.

6. Health and Wellness Coaching

a. Health and Wellness Education, Coaching and Health Promotion Programs

CCHP/BH organizations believe that evidence-based health and wellness promotion activities should be an integral component of mental health services seeking to provide overall wellness and recovery for persons with SMI.

As described in our response to Section 7. 2. D. 2, we have significant experience providing health and wellness to our Enrollees, including an active Health and Wellness Committee, staff training in Executive Order 509 nutrition standards with many programs offered related to nutrition, tobacco cessation programs, self-management of chronic medical conditions and many more.

We will leverage this experience to establish a comprehensive, evidence-based Health and Wellness program that meets or exceeds all of the requirements detailed in Section 2. 3. F of Attachment A.

We recognize, however, that some Enrollees will be in greater need of health and wellness education, coaching, and intervention than others. In some cases, general educational information will suffice. In others – for example, when an Enrollee is significantly overweight, sedentary, or is struggling with tobacco use – more intensive interventions may be required. We understand that wellness programs of longer duration (3 or more months), which combine education and activity, and incorporate both nutrition and physical exercise are more likely to be effective than are programs of shorter duration, those focusing on only one factor (e. g. nutrition or exercise), or unstructured, education-only programs. As a CP organization, we will seek to establish collaborative wellness initiatives with ACOs and MCOs to deliver comprehensive health and wellness initiatives to CP Enrollees, and we expect to partner with the Enrollee's ACO or MCO for higher-intensity wellness programs.

b. Ensuring the Engaged Enrollee's Goals are Recorded and Tracked

Assessment of an Enrollee's need for health and wellness information, coaching, or other intervention will occur as part of the Comprehensive Assessment during which we will identify any high-risk behaviors, including poor nutrition, overweight or obesity, lack of exercise, and other risk factors. Any health or wellness-related need will be shared with the Care Team, and the Enrollee's ACO or MCO, and the Care Team's recommended PCTP – which will reflect the Enrollees' self-identified goals and objectives – will be included in the Enrollee's PCTP. The

Enrollee's participation in the recommended Health and Wellness program(s) and ongoing progress will be monitored by the Care Team, with periodic updates provided to the Enrollees ACO or MCO Care Coordinator or Recovery Support Navigator.

7. Connection to Community and Social Services

a. Plans to Evaluate Engaged Enrollees for Social Service Needs and Screening Tool(s)

As described in response to Section 7. 3. B. above, the CCHP/BH has longstanding existing relationships with community and social service agencies in our service area. We will leverage these relationships to ensure access to needed supports to address the social determinants of health that effect how Enrollees interact with the system.

We currently employ processes to refer and coordinate with community service providers and social service agencies, and will leverage these existing processes to facilitate ongoing communication and information-sharing and ensure that Enrollees have timely access to needed community supports.

Our formal current and planned approaches include:

- Appointing dedicated points of contact for ACOs and MCOs
- Executing memoranda of understanding with providers and community organizations regarding the delivery and coordination of services
- Appointing liaisons to foster relationships and communication with community agencies For the BH CP Comprehensive Assessment, CCHP/BH will utilize the Massachusetts Standardized Documentation Project (MSDP) tool.

b. Ensuring Care Coordinators are Familiar with a Wide Breadth of Social Services and Supports and Providers of these Supports

We will jointly develop processes and procedures with ACOs in our service area to collaborate and coordinate in the delivery or facilitation of access to services authorized by the ACO. Care Coordinators will work with ACO Care Coordinators for Engaged Enrollees to identify such supports (as documented and authorized by the ACO) and jointly establish a plan for providing or arranging for them (as appropriate). Such services will be included in the Enrollee's care plan, and monitored by the Care Team.

c. Strategies for Collaborating with ACOs to Recommend Flexible Services on Behalf of Engaged Enrollees and Following-Up on the Outcomes

Specific strategies for collaborating with ACOs and MCOs include:

- Upon the execution of the partnership, we will provide the ACO or MCO a detailed orientation to our organization, services provided or facilitated, structure and operations of our Care Team model, and contact information;

- Establish and facilitate a joint Care Coordination Planning Committee to develop processes and procedures to ensure communication and collaboration between the two organizations' care management teams
- Establish and maintain a cadence of periodic joint care management meetings (telephonic, WebEx, face-to-face) to ensure appropriate communication, collaboration, follow-up and accountability
- Conduct joint trainings (initial and periodic) with all members of the CP care team
- To the extent allowed by the patient, share care plans, progress reports, status reports, and other pertinent information about Engaged Enrollees with the ACO/MCO

D. Innovative technologies for service delivery

CCHP/BH and its Affiliated Partners are proficient in the use of technology to facilitate consistent and accurate documentation and provide effective and efficient services to Enrollees in their homes and community settings. We maintain electronic medical record systems that will integrate into a centralized care management system to document and track all BH CP qualifying activities and more.

CCHP/BH intends to partner with eHana to develop a statewide Community Partner Care Management platform, built to meet the specific requirements of the Community Partner program. Under this approach, a single "hub" will be provisioned for use by a group of Community Partners, simplifying integration with EOHHS, ACO/MCOs, and other stakeholders, improving collaboration and coordination. CCHP/BH will integrate our Electronic Health Record applications (whether eHana or other) with the Care Management platform. Data related to enrollee Assessments, Care Plans, Services/Qualifying Activities, as well as necessary workflows and approvals, will be managed within the Care Management Platform. This approach provides several benefits: (a) it centralizes and simplifies integrations with EOHHS, ACO/MCOs and other stakeholders; (b) it encourages standardization of workflows and reporting between CPs, reducing overall infrastructure costs and improving sustainability; (c) it provides a centralized hub from which social and flexible support providers may receive referrals, document follow-up, and collaborate on enrollee care.

We will employ tools that enable and support real-time Care Team collaboration, including mobile-optimized chat experiences. Chat is a key emerging technology, both within and outside of healthcare; with enrollee-centered Care Team discussions, members can collaborate in individual enrollee "chat rooms" and track progress, while automated alerts and notifications provide additional context and prompt team member action. We currently equip our Care Coordinators and care management staff with mobile technologies, including tablet computers and smartphone applications to support their ability to engage Enrollees, meet Enrollees where they are to complete assessments, care planning, and to help Enrollees locate providers and local resources. Care Coordinators as well as all members of the BH CP care team will be able to log into the care management platform from tablet computers, enabling them to document Enrollee contacts, clinical information, and services delivered.

In addition, we use a variety of smartphone apps in our clinical/wellness work. They include:

Mood Tracker; Panic Shield: Panic Attack; Recovery Apps (Mental Health Recovery Guide, My Recovery App); Self-esteem Building Guide; Virtual Hope Box, Insight Timer; You Tube, Recovery Record (for eating disorders); and self-soothing apps. For caregivers we use Provider Resilience, Tec-Tec, an evidenced-based app for reducing non-suicidal self-injury and suicidality. These apps will be incorporated into our work with BH CP Enrollees as applicable.

E. Personnel and staffing

1. Organizational Chart

We provide our organizational chart as Attachment 7.3.E-1, identifying personnel who will be assigned to accomplish the Contractor responsibilities described in Attachment A.

2. Sample Staffing Model

These changes in staff positions are also reflected in the revised budgets and budget narrative submissions. We propose serving up to 1703 BH CP Eligible Enrollees within our overall Service Region, as detailed in Section 7.2.A., Attachment D. Our staffing model will include the following positions and number of full-time equivalents (FTEs).

Table 7. 3. E. 2. Staffing Model for at least 1750 BH CP Enrollees

Positions	FTEs
Administration	
Director	. 81
Quality Analyst	.81
Intake Coordinator	. 81
Administrative Assistant	.81
Supervisors	
Senior Clinical Care Manager (Lic. Clinician-Team Lead)	1.0
Senior Nurse Manager (RN -Team Lead)	1.0
Medical Director	.01
RN	2.27
Care Management	
Clinical Care Managers (Lic. Clinician)	2.37
Clinical Care Managers (s) (RN)	2.41
Care Coordination	
Care Coordinators (1:45)	37. 84
TOTAL	51.57

3. Recruitment Plan

Recruitment Plans for the CCHP:

- Upon award, we will begin recruitment for the management, clinical care, nursing and care coordinator positions.
- We will work with the ACO/MCO's to determine Eligible enrollee numbers and geography in our service area to aid in planning for the care management staff needed for program launch in April.
- We will expand partnerships with local colleges to recruit using programs that include career fairs, internships, shadowing, and may include innovative programs like student loan payment stipends.
- We anticipate starting the program with care management staffing that includes: 1 Clinical Care Manager, 1 RN, 4.5 Care Coordinators.
- Recruitment will continue for additional care coordinator and clinical care managers in anticipation of the CBFS eligibility pool becoming Eligible in July.
- We will continue to recruit for positions in advance of program growth, using the budget periods as milestones for assessment of enrollment and attrition rates, so that all staff is appropriately trained before they interact with individuals served.

Position	Begin Recruitment	Target Hire Month
Director	October 2017	December 2017
Clinical Care Manager	December 2017	March 2018
RN	December 2017	March 2018
Care Coordinator	January 2017	April 2018
Referral Coordinator	December 2017	March 2018
Admin Assistant	June 2017	BP1
Quality Analyst	December 2017	February 2018
Sr Clinical Care Manager	December 2017	March 2018

The CCHP/BH recruitment plans for care management positions will seek candidates that possess both academic credentials and or applicable experience in clinical settings, community health work, peer specialists, and or recovery coach along with knowledge and experience of local resources, navigating health, behavioral health and substance abuse treatment systems.

Job descriptions are provided as Attachment 7.3.E-3.

4. Process to Recruit and Hire Staff

The CCHP/BH is committed to ensuring that staff are representative of the communities we serve. We recognize that culture encompasses more than linguistic diversity, and includes racial or ethnic background, national origin, immigration/refugee experience, physical or mental disability, gender and gender identity, and sexual orientation. To that end, we take care to ensure that our providers, staff, and volunteers are responsive to the linguistic, cultural, ethnic, or other unique needs of all Enrollees. We will gather information from each Affiliated Partner to verify their capacity to provide culturally and linguistically appropriate services. We will also utilize existing community needs assessments and studies, and will work with our ACO and MCO partners to maintain ongoing demographic, cultural, and epidemiological profile of the community. This information will be used to identify both hiring priorities and training needs to increase sensitivity to the needs of individuals from different cultural and ethnic backgrounds. We will work closely with community-based organizations (e. g. immigrant and refugee coalitions, advocacy coalitions, LGBTQ advocacy agencies) to identify and leverage opportunities for targeted recruitment activities. We currently have job fairs in communities throughout the region and will partner with ACOs and MCOs to conduct job fairs in specific communities and in languages other than English (where possible).

However, we recognize that recruitment of a diverse behavioral health workforce – particularly though not exclusively for substance use and behavioral health providers – is a nationwide challenge, with numerous systemic barriers that will be difficult to overcome. To that end, we will evaluate utilizing DSRIP funds for short-term workforce development strategies (for example, signing bonuses for employees with specific language skills), and implement a longer-term initiative to review and potentially augment our staff retention programs, including ongoing career development, educational assistance, on-going licensing and credentialing opportunities, and leadership training.

5. Proposed Training, Orientation Plans and Modules for Staff

CCHP/BH organizations manage training programs for our staff that help them better understand the needs of high utilizing individuals with SMI or SUD. As we do today, we will train our CP staff on these topics and will leverage existing training modules to develop comprehensive CP training. We will also provide refresher training, as well as updated training on best practices, at least annually. We will finalize training modules and training schedules prior to the contract effective date. Below are examples of potential training modules:

Listing of Proposed Training Modules	
Understanding and awareness of the needs of high utilizing individuals with SMI or SUD	• Chronic Illnesses and Serious Mental Illness/SUD • Recovery and Resiliency • Overview of Intellectual, Cognitive, and Developmental Disabilities • LTSS Services: What are LTSS Services, Who Provides them, and How Do We Work Collaboratively?

Understanding Community Partner Supports	• Scope of services • Partnership and Collaboration with ACOs/MCOs • Comprehensive Assessment and PCPT • Flexible Service: Resources, referral, follow-up • Collaboration and Communication with community agencies
Cultural Perspectives – Recognizing sensitivities to different cultures, religions, values, and backgrounds	• The Impact of Culture on health and health care (with focus on SMI/SUD) • Health Disparities • Culturally Competent BH Care Delivery • Minority racial, ethnic and other communities (e.g. the LGBTQ Community
Treatment Intervention Approaches	Engagement & Outreach Wellness Coaching Tobacco Cessation Motivational Interviewing

We will partner with ACOs and MCOs to hold periodic conferences for Enrollees, staff, advocates, LTSS-CPs, social service and community agencies to which Subject Matter Experts (including experts from the ACOs, MCOs and ILCs) will be invited to present. We will facilitate staff training by: making work hours available for staff to participate on a mandatory basis; tracking participation; enabling online evaluations and scoring; and, providing resource guides and training materials to reinforce learning. We will also work with ACOs and MCOs to develop and deliver trainings in topics of mutual and common interest, such as care coordination strategies, community collaboration and cultural competence.

We will leverage existing MassHealth training and resources into staff trainings and material, encourage MassHealth training forum attendance and ensure staff interacting with Enrollees with BH needs complete required training on BH competencies.

6. Description of Staff Retention Strategy

As referenced above, there are systemic challenges and barriers to recruiting and retaining qualified, trained and experienced staff. We will address these challenges with a long-range, comprehensive, multi-pronged strategy, including ongoing career development, educational assistance, ongoing licensing and credentialing opportunities, and leadership training.

In the short term, we hope to use DSRIP funds for certain defined workforce development initiatives, including staff retention efforts. We propose collaborating with other BH CPs, ACOs and MCOs to explore opportunities for collaborative efforts to develop and implement staff retention programs, including professional development. Potential areas of focus include:

- Strategies to encourage workforce to continue to earn degrees in higher education and professional credentials

- Provide leadership training and management skills development training to support staff who seek to advance in their careers
- Provide on-going opportunities for continuing education for licensing and credentialing

We recognize that being able to raise salary levels and benefits would likely result in better retention, but we do not believe that the current environment will allow for this. However, there are additional non-financial benefits that can also aid in retention by improving staff experience in the workplace. These include:

- Fostering an enhanced sense of ownership and accountability among staff by expanding our existing mechanisms to solicit, obtain, and incorporate (to the extent appropriate) staff input into program development, administration, and management
- Cultivating a supportive organizational culture by providing more focused and personalized management, supervision, and mentoring
- Exploring opportunities to reduce the administrative burden on staff by streamlining recordkeeping and other documentation requirements including consideration of a work from-home policy or environment

Exploring and implementing creative work allocation and scheduling to allow staff to achieve a healthy work-life balance.

F. Implementation Plan and Timeline

We provide implementation timelines for the Preparation Budget Period and each subsequent Budget Period in Attachment 7.3.F.

G. Budget Report and Budget Narrative

We provide our completed Budget Report and Budget Narrative in Attachments 7.3.G-1 and 7.3.G-2 respectively.

H. Sustainability

CCHP/BH will sustainably fund the proposed infrastructure and capacity building investments for BH CP services during the Contract Term and following the initial Contract Term through:

- DSRIP Dollars (initial investment and ongoing funds distribution associated with volume
- Developing shared savings initiatives with the ACOs/MCOs
- Selling services to MCOs for non-CP eligible individuals who can benefit from CP services to manage the Total Cost of Care (TCOC) for more Enrollees
- Managing fixed costs associated with IT, licensing, fees and general expenditures over time
- Identifying and developing new services for ACO, MCO and Commercially enrolled individuals that support consumers remaining independent in the community and decrease TCOC associated with avoidable hospital utilization.

I. Quality Management and Performance Monitoring ()

1. Quality Improvement Program

CCHP/BH will collaborate with our Affiliated Partners to create a Quality Management/Quality Improvement (QM/QI) Program that supports our mission to deliver integrated, quality, cost effective BH CP services that enhance outcomes and decrease the Total Cost of Care. CCHP/BH will measure and improve multiple aspects of BH CP services including, but not limited to: clinical quality of care, care coordination, access and availability, continuity and Enrollee experience. We will apply a data-driven, evidence-based approach to BH CP service delivery and analyze and compare data against internal, local, and state benchmarks to identify opportunities for improvement. We will establish goals, processes, and include an interdisciplinary committee structure that includes Enrollees, family members and CCHP/BH representatives.

Applying Principles of Continuous Quality Improvement

CCHP/BH's QM/QI Program will build on current CCHP/BH QM/QI activities including continuous monitoring of quality performance measure indicators and clinical practice guidelines. Our goal is to deliver quality care that helps Enrollees maintain and improve health and wellness. Our objectives are to: improve clinical quality; improve coordination of care; improve access to services; and, enhance all aspects of the Enrollee experience. We will achieve our goal and objectives by relying on data-driven decision making, evidence-based practices and expert advice to drive improvement. We will improve care by: using data to identify and address anomalies in care and outcomes; developing interventions to ensure that goals are achieved; and completing objective measurement processes and implementing improvement initiatives.

We will obtain information for quality monitoring and improvement from several sources including but not limited to: medical record review, Enrollee and/or provider complaints, utilization review, and survey data. We will use this information to inform our quality initiatives and establish target goals. We will measure progress toward those goals and modify interventions as appropriate to ensure effectiveness.

The QM/QI Program will define: clear assignment of roles and responsibilities to each Affiliated Partner; performance benchmarks in alignment with program goals and contractual requirements; and Enrollee satisfaction measures. The program will include meaningful roles for Enrollees and their families in QM/QI activities on advisory councils; monitoring processes to review medical record-based studies; and, plans to monitor Care Management service delivery. Consistent with our current approach, we will compare outcomes across CCHP/BH partners individually and in the aggregate, comparing results to baseline to assess our performance in meeting goals, and to advance performance by establishing outcome objectives.

QM/QI Plan

Our QM/QI Plan and Annual Work Plan provide a blueprint to achieve quality goals and document our activities to address all contractual QM/QI requirements. We will continually

update the QM/QI Plan based on stakeholder input and data analysis. We will also maintain an Annual Quality Workplan that delineates a core set of performance metrics and is updated based on the annual review of systems. We will define strategies to address QM/QI priorities.

Annually, we conduct a comprehensive program assessment that examines QM/QI program effectiveness, service utilization, cost, quality data and the prior year's outcomes. We will continue this approach for the BH CP Contract. Progress toward goals will be reported to the Quality Committee, which will determine opportunities for improvement, design interventions, and track the effectiveness of interventions. In this way, we will ensure our QM/QI program is relevant to the population we serve, and results in better Enrollee care.

2. One Proposed Quality Initiative

CCHP/BH is committed to improving Enrollee care by enhancing the quality of services we provide. To that end, we propose to implement a quality initiative related to enhancing Care Coordination and Care Management for high-cost, high-risk Enrollees served by the MassHealth program. Specifically, we propose to increase the number of BH CP Eligible Enrollees who receive fully integrated BH CP services in collaboration with an ACO Partner.

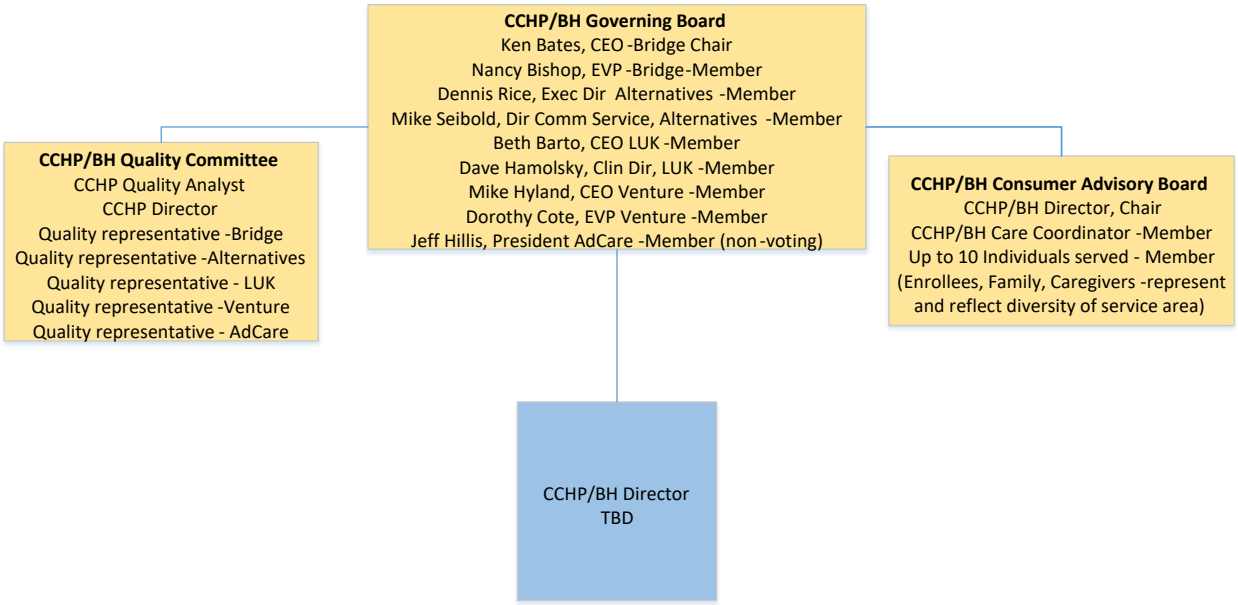
Description: For this QM/QI effort, CCHP/BH will develop a joint process with at least one ACO Partner in our geographic area to perform a Comprehensive Assessment and to develop a joint Interdisciplinary Care Plan (ICP) for at least 50% of the engaged BH CP Eligible Enrollees who are served collaboratively by the BH CP and the ACO. Under this process, the BH CP will work with the ACO to implement a joint person-centered process where data elements that are required by both the ACO Comprehensive Assessment and the MSDP Comprehensive Assessment are shared, based on which organization obtains the data first, with the Enrollee's permission. Then, CCHP/BH will either participate on the ACO's ICT or, we will invite the ACO to participate in our ICT. The joint ICT will include the Enrollee's PCP, family and/or informal caregivers, the ACO Care Manager, the CCHP/BH Care Coordinator or Recovery Support Navigator and any other individuals who the Enrollee wishes to participate on the Team. CCHP/BH will develop and document an integrated ICP in collaboration with the ACO. The BH CP will then implement the ICP and continue to work with the ACO to integrate care.

Target Population: The target population for this initiative includes high-risk, high-cost actively engaged ACO Enrollees who are BH CP Eligible.

Measures for Success: We will measure the percentage of actively engaged BH CP Eligible Enrollees who are jointly served by the ACO and CCHP/BH who receive a fully integrated Comprehensive Assessment prepared jointly by the CCHP/BH Care Coordinator or Recovery Support Navigator and the ACO (divided by the total number of actively engaged BH CP Eligible individuals). For the first year of the Contract, we propose a 60% success rate for this measure. We will implement this initiative in Budget Period 1 and continuously evaluate the effectiveness of this initiative in meeting established goals with monitoring through our Quality Committee.

3. Functions of Quality Committee and Composition and Reporting Structure

CCHP/BH will maintain a Quality Committee that drives improvement through the review of data and incorporates Enrollee and family feedback. Building on quality structures within each of the CCHP/BH partners, our Quality Committee will meet monthly and will be responsible for: identifying quality improvement opportunities; finalizing intervention strategies to improve quality and cost effectiveness; establishing timeframes for interventions; and tracking the effectiveness of interventions and making modifications to improvement strategies, as needed. The Quality Committee will report to the Governing Board as illustrated in Figure 7.3.I.3.



Our Committee structure will include:

Governing Board: The Governing Board will include two representatives from The Bridge as the Lead Agency with its Affiliated Partners and the CCHP/BH Director, all of whom have voting rights. This committee will serve as the decision-making authority for the BH-CP and provide strategic direction and programmatic oversight. The Governing Board will be chaired by the CEO of the Lead Agency. AdCare, as a Material Subcontractor, will have one non-voting member.

Quality Committee: Performance data will be reported to the Quality Committee which analyzes data against program goals and develops performance improvement initiatives. The Quality Committee will meet monthly and include one representative from each CCHP/BH partner. The Committee will be chaired by the CCHP/BH Director and will report to the Governing Board.

Consumer Advisory Board (CAB): The CAB will ensure that services delivered are consistent with CCHP/BH's mission and values, identifying service gaps and solutions to address them, and gathering direct feedback regarding service delivery from individuals served, staff and other direct care workers. We will inform changes in policy and practice based on information and

feedback provided by the CAB. The CAB will be comprised of up to ten consumers and two staff, one of whom will be the Director.

J. Coordination with ACOs and MCOs

CCHP/BH is aware that an essential part of the success of the BH CP contract relies on our shared ability to coordinate key elements of our infrastructure with ACOs and MCOs in our service area. We believe that Enrollees will be best served by the ACO or MCO sharing a single, modular Comprehensive Assessment and ICP that supports complete, up-to-date integrated Enrollee information across organizations, including state agencies and community-based organizations. Such sharing of information is crucial to the delivery of integrated care management and represents an opportunity to achieve savings on infrastructure and IT resources. We will begin with a compliant, functioning solution to support care integration; however, over time, our desire is to have a fully integrated system capable of supporting shared assessments, care plans, reporting and quality management functions. We are already collaborating with ACO and MCO partners in our service area and will continue to support such collaboration.

1. Communication of Skills Expertise and Value to Potential ACOs and MCOs

We have met with Reliant/Fallon and UMass to discuss our skills, expertise and value to care integration efforts. Such discussions will continue as BH CP, LTSS CP, ACO and MCO contracts are awarded by EOHHS. We are communicating with, and educating ACOs and MCOs regarding:

- Our shared responsibility in caring for MassHealth consumers with the greatest needs and level of risk, given their SMI and/or SUD diagnosis
- The contribution that the CCHP/BH can make to delivering quality care for individuals with SMI and SUD diagnoses including, integration, patient satisfaction and Total Cost of Care (TCOC) among other measures, all of which will be vitally important to our Enrollees and to our organization, ACOs and MCOs in our joint efforts to deliver care
- The breadth and depth of BH CP services available to Eligible Enrollees including, the specialized nature of the BH CP component of the Comprehensive Assessment, the Individualized Care Plan and ongoing care plan implementation and monitoring
- The importance of primary care delivery for individuals with SMI and SUD, many of whom go without primary care services for a variety of reasons. One of our goals is to ensure that individuals with significant BH diagnoses receive primary care services, given that such individuals die, on average, 25 years earlier than their peers without an SMI diagnosis.
- Collaborative strategies to integrate primary care and BH care for BH CP Eligible Enrollees in the assessment, care planning and care delivery process.
- Strategies to engage individuals with an SMI or SUD diagnosis and build upon existing relationships with providers
- The use of evidence-based practices to teach self-management skills and promote wellness

2. Branding and Marketing Plans the Bidder Has Regarding Its Relationship with ACOs and MCOs

The CCHP/BH branding and marketing plans will be guided by MassHealth policy and procedure, which clearly prohibits MassHealth vendors from directly marketing to Enrollees. Our priority will be to serve Assigned Enrollees who have a pre-existing relationship with our organization. For Marketing and Branding, we plan to:

- Develop a consumer awareness campaign to communicate the value and enhance access to BH CP services for individuals with significant BH needs. Materials will be made available to ACOs and MCOs in the most commonly spoken languages in the service area and can be distributed to Enrollees as part of the Enrollment process.
- Educate ACO and MCO partners regarding our services, our approach to Enrollee services and the nature of integration we offer, which will benefit Enrollees.
- Meet with ACO's and MCO's in the Central Region to coordinate and align our branding and marketing strategies including the development and implementation of successful ACO / MCO educational materials and presentations to key stakeholder groups, including but not limited to the following: ACO enrollees and their families; providers and clinicians; staff; and strategic partners. These materials and presentations will be designed to communicate the specialized experience, skills, expertise and value the CCHP/BH possesses and how we will enhance the coordination and management of service delivery for Enrollees.

3. Strategy to Engage and Collaborate with Multiple ACOs and MCOs

The CCHP/BH will provide information and reach out to develop relationships with all ACO and MCO partners in the Service Areas for which this bid applies.

4. Strategy for Conflict Resolution

The CCHP/BH will partner closely with ACOs and MCOs in the Service Region to serve the needs of BH CP Eligible individuals. We will leverage and build upon the strengths that our organization, and our partner organizations, bring to this engagement. While we do not anticipate disagreements in areas of shared responsibility, we recognize that differences of opinion may arise, specifically related to care management decisions that affect Enrollees or, the way the Contract is managed. Our mutual intention is to resolve those disagreements in a timely manner that causes no harm whatsoever to Enrollees and, maintains compliance with the terms of the contract. In general, the forum for resolving disagreements and conflicts between CCHP/BH and an ACO or MCO will be addressed by the Governing Board. Going forward, we will create a structured process to escalate issues of significant financial impact or other major strategic issues. Consistent with the principles guiding the work of the Governing Board, the decision-making processes will be transparent, and all decisions must be supported by data. The Governing Board will solicit input from each organization and, if necessary, other stakeholders using any available data (e.g. financial, quality, contractor performance, etc.) to inform its decisions. Any disagreement or conflict that cannot be resolved at the staff level will be escalated to the Governing Board. We anticipate that this escalation will rarely be necessary.

Community Partner Program Budget Report

Brien Center

	Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
	Estimated Enrollees- Start of Period (All Enrollees)		0	1,025	1,200	1,250	1,350	
	Estimated Enrollees - End of Period (All Enrollees)		1,025	1,200	1,250	1,300	1,400	
	Estimated Enrollees - Monthly Average (excl CBFS enrollees)		430	475	550	700	750	
	Estimated Enrollees - Monthly Average (CBFS enrollees only)		176	266	260	288	328	
	Estimated Program Revenue (excl CBFS enrollees)		$ 541,800	$ 1,026,000	$ 1,188,000	$ 1,512,000	$ 1,620,000	$ 5,887,800
	Estimated Program Revenue (CBFS enrollees only)		$ 308,000	$ 798,000	$ 780,000	$ 864,000	$ 984,000	$ 3,734,000
	Total Estimated Program Revenue		**$ 849,800**	**$ 1,824,000**	**$ 1,968,000**	**$ 2,376,000**	**$ 2,604,000**	**$ 9,621,800**
	At- Risk Withhold Rate			0%	0%	0%	0%	
	Withhold funds			$ -	$ -	$ -	$ -	$ -
	Revenue for Operations		**$ 849,800**	**$ 1,824,000**	**$ 1,968,000**	**$ 2,376,000**	**$ 2,604,000**	**$ 9,621,800**

	Program Expenses		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
1	**Salary**		$ 65,148	$ 332,777	$ 833,188	$ 946,551	$ 966,966	$ 1,011,338	$ 4,155,968
2	**Fringe**		$ 14,984	$ 75,374	$ 207,589	$ 259,416	$ 291,513	$ 335,378	$ 1,184,254
	Total Personnel Costs		$ 80,132	$ 408,151	$ 1,040,777	$ 1,205,967	$ 1,258,479	$ 1,346,716	$ 5,340,222
3	**Training & Professional Development**		$ 5,000	$ 12,500	$ 21,000	$ 23,400	$ 27,500	$ 27,500	$ 116,900
4	**Travel**		$ 1,080	$ 11,900	$ 32,400	$ 36,000	$ 39,000	$ 42,000	$ 162,380
5	**Equipment**			$ -	$ 1,000	$ 1,000	$ 1,000	$ 2,000	$ 5,000
6	**Supplies**		$ 8,700	$ 23,984	$ 41,400	$ 42,063	$ 42,198	$ 45,900	$ 204,245
7	**Contract Services** (consulting, professional)		$ 7,200	$ 89,750	$ 186,000	$ 191,000	$ 162,400	$ 166,000	$ 802,350
8	**Software licensing**								$ -
9	**Telecommunications**		$ 780	$ 8,540	$ 16,640	$ 17,040	$ 17,040	$ 17,040	$ 77,080
10	**Occupancy** (rent, utilities, maintenance)		$ 7,500	$ 35,000	$ 56,500	$ 67,375	$ 71,475	$ 73,275	$ 311,125
11	**Other**		$ 2,500	$ 10,500	$ 21,000	$ 30,000	$ 36,000	$ 36,000	$ 136,000
	Total Direct Costs		$ 112,892	$ 600,325	$ 1,416,717	$ 1,613,845	$ 1,655,092	$ 1,756,431	$ 7,155,302
12	**Indirect Cost/Administrative Overhead**	**15.0%**	**$ 16,934**	**$ 90,049**	**$ 212,508**	**$ 242,077**	**$ 248,264**	**$ 263,465**	$ 1,073,295
	TOTAL EXPENSES		$ 129,826	$ 690,374	$ 1,629,225	$ 1,855,922	$ 1,903,356	$ 2,019,896	$ 8,228,597
	Surplus/Shortfall		*$ (129,826)*	*$ 159,426*	*$ 194,775*	*$ 112,078*	*$ 472,644*	*$ 584,104*	*$ 1,393,203*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Director of Care Coordination	$ 62,000.00	1	4.8	$ 24,800
Care Coordinator	$ 54,230.00	2	2	$ 18,077
BH CP Nurse	$ 53,450.00	2	2	$ 17,817
BH CP Nurse	$ 53,450.00	1	1	$ 4,454
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary (Program Budget Line 1)		**6**		**$ 65,148**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 65,148	23%	$ 14,984
Total Fringe (Program Budget Line 2)			**$ 14,984**

Total Personnel*	**$ 80,132**

* Should align with Personnel Costs row in Program Budget

1. Director of Care Coordination: Primary program management responsibility for BH-CP contract and primary programmatic contact with ACO and ACO partners. Oversight of staff at 2 locations.
2. Care Coordinator- Coordinate client care and access to services and supports with client. Works with BH RN, Community Health Workers, Recovery Coach Navigators , primary care, behavioral health and LTSS service providers and other ACO partners.
3. BH CP Nurse - Provides initial and follow up assessments, develops care plans based on comprehensive clinical assessments, provides client medication reconciliation, coordinating care information with ACO and primary care and necessary service providers. Salaries are estimates

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
general expenses for training		10	$ 5,000.00
Total Training and Professional Development (Program Budget Line 3)			**$ 5,000.00**

General cost estimate for staff training on CP care model, ACO referral and tracking process, policies and procedures, cultural competencies, LTSS services, implementation of care management model, ACO and eHana care management software.

Training for Director (1), care coordinators (2) and RNs (3) , quality (1), intake coordinator (1), information systems (1) and support staff (1) = 10 positions

training modules will include:
1. Understanding and awareness of the needs of high utilizing individuals with SUD or SMI.
2. Understanding community partners supports
3. Cultural perspectives/ cultural awareness with a focus on SMI/ SUD

This will involve bringing in resources on multicultural practices, professionals in LTSS services and care management. Will also include involvement with peer CP programs .

It is anticipated that EOHHS or lead provider groups will offer some centralized training on

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
Director of Care Coordination	200	5	0.43	$ 430
Care Coordinators	200	2	0.43	$ 172
Care Coordinators	200	2	0.43	$ 172
BH CP Nurse	142	2	0.43	$ 122
BH CP Nurse	142	2	0.43	$ 122
BH CP Nurse	143	1	0.43	$ 61
			Total Mileage	$ 1,080

Travel Expense Description	Cost
Total Mileage	$ 1,080
Parking and tolls	
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ 1,080**

Estimate of mileage during prep period visiting primary care and other ACO partner offices, meetings and trainings with ACO and other resources travel between clinical offices in northern, central and southern Berkshire county. It is expected that the director will attend regional EOHHS and peer CP meetings for coordination and implementation of the program.

Row 5 - Equipment

Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost

	A	B	C	D	E	F
92						
93						
94						
95						
96						
97						
98	**Total Equipment (Program Budget Line 5)**					
99						
100						
101						
102						
103						
104	**Row 6 - Supplies**					

105	Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
106	General start up office supplies	250	10	$ 2,500.00
107	clinical supports supplies RNs & care coord	$450.00	5	$ 2,250.00
108	Outreach supplies and material			$ 3,500.00
109	copier/ fax			$ 450.00
110	**Total Supplies (Program Budget Line 6)**			**$ 8,700.00**

111
112
113 ***Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:***
114
115
116 ***General office supplies for program start up for the Director (1), care coordinators (2) and RNs (3) , quality (1) and intake coordinator (1)and information systems (1) , support staff position (1) = (10FTE)***
117
118
119
120 ***Clinical support supplies include form prep and printing of client related forms, gloves, BP and O2 monitors, scales and protective supplies for RNs (3) and care coordinators (2)= 5 FTE.***
121
122
123 ***Outreach supplies include preparation of handouts and material to inform clients of available services, health promotion and other materials. Will include preparation of material for mailing to eligible clients on the program.***
124
125
126
127
128 **Row 7 - Contract Services**

129	Name of Contractor	Contractor Type	Goods and Services Provided	Cost
130				
131	Donna Mattoon, Assoc	community relations	marketing	$ 1,200.00
132	Health Policy Matters LLC	care mgmt. policy	prog tech ass	$ 4,000.00
133	Cohen Kinne Valicenti & Cook LLP	legal	legal	$ 2,000.00
134				
135	**Total Contract Services (Program Budget Line 7)**			**$ 7,200.00**
136				

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Donna Mattoon Assoc. - developing community relations / marketing strategy assistance with making general public aware of program, developing strategies to do outreach to prospective clients and families . This will include media information on program and services and follow up . 14 hours @ $75/ hr.

Health Policy Matters- technical assistance in developing in implementation and roll out plan based on national best practices. 20 hours @ $250/ hr.

Cohen Kinne Valicenti & Cook LLP - legal advisor for ACO and EHR contracting ; 8 hours at $250.0

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
		Total Software Licensing (Program Budget Line 8)	

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

software licensing for eHana care management software is covered within the software development expense on the infrastructure budget. Any licensing fees by the ACO are unknown at this time. An general estimate of ACO connect fees is included in the infrastructure budget

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Director 5 months	60	1	$ 300.00
RN s 2 months x 2	60	2	$ 240.00
Care coordinators-2 months x 2	60	2	$ 240.00
		Total Telecommunications (Program Budget Line 9)	**$ 780.00**

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Smartphone data access for staff .

Data card access for online access to EHR and other resources while in client homes and remote sites will be added in

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent	900	20	$ 7,500.00
Utilities			
Repair and Maintenance			
			$ -
			$ -
Total Occupancy (Program Budget Line 10)			**$ 7,500.00**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

While some of occupancy expenses will be absorbed during the start up period, a preliminary amount is being budgeted to secure and reallocate space near the Brien Center main 333 East Street clinic facility.

9 FTEs using this space x100 sq ft x estimate of $20/ sq ft=$18,000/12 months x5 months = $7500
IT staff person will be based in IT office and not the program area.

Row 11 - Other

Other Direct Expense Description	Cost
meeting expenses / outreach exp	$ 2,500.00
Total Other (Program Budget Line 11)	**$ 2,500.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Hosting group meetings / focus discussions in northern, central and southern Berkshires with primary care physicians, LTSS and other area providers of and general members of the community to foster collaboration and

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	**15.00%**	**$16,934**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

	A	B	C	D	E	F
232						
233	***updated indirect rate as of 9/30/17 for general administrative, management, IT and fiscal support to the program .***					
234	***15.6% - capped at 15% on budget***					
235						

Community Partner Infrastructure Budget Report

		Brien Center						
	Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
	PMPM Infrastructure Rate		$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
	Engaged Enrollees		1,025	1,025	1,200	1,250	1,300	
	Estimated Infrastructure Funds		$ 717,500	$ 1,058,415	$ 741,456	$ 681,000	$ 612,768	**$ 3,811,139**
	At- Risk Withhold Rate			25%	44%	63%	81%	
	Withhold			$ 264,604	$ 326,241	$ 429,030	$ 496,342	**$ 1,516,216**
	TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 717,500	$ 793,811	$ 415,215	$ 251,970	$ 116,426	**$ 2,744,923**
	Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
	Technology							
1	**IT Staffing including Fringe**	$ 24,344	$ 34,978	$ 61,761	$ 63,614	$ 65,523	$ 67,488	**$ 317,708**
2	**Development Adaptation of EHR and/or Care Management System**	$ 195,000	$ 84,868	$ 66,800	$ 77,200	$ 81,000	$ 109,280	**$ 614,148**
3	**Technology for Service Delivery**	$ 11,000	$ 1,000	$ 1,500	$ 1,000	$ 2,500	$ 1,500	**$ 18,500**
4	**Other Technology Expenses**	$ 5,000	$ 20,000	$ 21,000	$ 20,000	$ 22,000	$ 12,000	**$ 100,000**
	Total Technology	$ 235,344	$ 140,846	$ 151,061	$ 161,814	$ 171,023	$ 190,268	**$ 1,050,356**
	Workforce Development							
5	**Workforce Development staffing including Fringe**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
6	**Recruitment Expenses**	$ 20,000	$ 5,000	$ 6,000	$ 3,000	$ 2,000	$ 2,000	**$ 38,000**
7	**Training Expenses**		$ 6,500	$ 6,000	$ 7,200	$ 7,200	$ 7,200	**$ 34,100**
8	**Retention Expenses**		$ 1,750	$ 3,000	$ 3,000	$ 3,000	$ 3,000	**$ 13,750**
	Total Workforce Development	$ 20,000	$ 13,250	$ 15,000	$ 13,200	$ 12,200	$ 12,200	**$ 85,850**
	Business Start Up Costs							
9	**Office Equipment (PBP & BP1 only)**		$ 1,500.00					**$ 1,500**
10	**Office Furniture (PBP & BP1 only)**	$ 8,975	$ 5,000.00					**$ 13,975**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**	$ 129,826	$ -	$ -	$ -			**$ 129,826**
	Total Business Start Up Costs	$ 138,801	$ 6,500	$ -	$ -			**$ 145,301**
	Operational Infrastructure							
12	**Operation Staffing including Fringe**	$ 26,318	$ 64,930	$ 144,014	$ 146,433	$ 148,925	$ 151,491	**$ 682,111**
13	**Other Operational Expenses**	$ 2,500		$ 6,000	$ 8,100	$ 6,000		**$ 22,600**
	Total Operational Infrastructure	$ 28,818	$ 64,930	$ 150,014	$ 154,533	$ 154,925	$ 151,491	**$ 704,711**
14	**Indirect Cost/Administrative Overhead Rate** 15.0%	$ 43,971	$ 33,829	$ 47,411	$ 49,432	$ 50,722	$ 53,094	**$ 278,459**
	TOTAL INVESTMENTS	**$ 450,000**	**$ 259,355**	**$ 363,486**	**$ 378,979**	**$ 388,870**	**$ 407,053**	**$ 2,247,743**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Information Systems Coordinator	$ 47,500.00	1	5	$ 19,792
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary			$ 19,792
	Fringe rate	23.0%	Total Fringe	$ 4,552
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 24,344**

Coordinate the introduction and management of eHana care management software and be primary contact in the testing and release of software; connection with Mass Highway messaging . Also work with ACO and ACO partners on software access to their systems and sharing of information between systems. Will assist with general IT operations up to .25 to enable other IT staff to assist with this software integration. More than 1 FTE will be dedicated to this project.

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
eHana care management software	$ 175,000.00

	A	B
34	estimate connection to ACO software and ACO	$ 20,000.00
35	fees	
36		
37		
38		
39	**Total Development and Adaptation of EHR and Care**	
40	**Management System**	$ 195,000.00
41	**(Infrastructure Budget Line 2)**	
42		
43		
44	***eHana care management software- to be utilized for client records, tracking and coordination of care, billing and data reporting.***	
45	***Cost is proposal based.***	
46		
47	***Estimate of connection to ACO and licensing fees.***	
48		
49		
50		
51		
52		
53		
54		
55		
56		
57		
58	**Row 3 - Technology for Service Delivery**	
59	**Description of Expense**	**Cost**
60	laptops and wireless mobile devices for staff	$ 11,000.00
61		
62		
63		
64		
65		
66	**Total Technology for Service Delivery**	$ 11,000.00

	A	B	C	D	E	F	G
67	**(Infrastructure Budget Line 3)**	**$ 11,000.00**					
68							
69	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
70	***contract and how the costs were determined:***						
71							
72	***estimate of $1000 per FTE X 10 FTE in budget hired in prep period and 1 FTE starting in month 1 of period 1 - for computers,***						
73	***tablets and smartphone technology. 11 FTE total***						
74							
75							
76							
77							
78							
79							
80							
81							
82							
83							
84							
85	**Row 4 - Other Technology Expenses**						
86	**Description of Expense**	**Cost**					
87	scanners and local printing devices	$ 2,500.00					
88	technical assistance for basic interface with EHR and	$ 2,500.00					
89	other systems						
90							
91							
92							
93	**Total Other Technology Expenses**	**$ 5,000.00**					
94	**(Infrastructure Budget Line 4)**						
95							
96							
97	***scanners/ local printers in multiple office locations. 5 at $500; 2 North Adams, 3 in Pittsfield.***						
98							
99							

Technical assistance is an estimate and will be provided by a to be determined outside source, based on the type of assistance needed . Work to fully intergrat e eHana with the EHR will be costed during the prep period and included in budget period 1 on infrastucture budget.

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)	**$ -**

recruitment will be handled by existing staff

Row 6 - Recruitment Expenses

Description of Expense	Cost
estimate of various recruitment options	$ 20,000.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 20,000.00**

costs are estimates based on previous recruiting for similar positions and programs. Methods used will include LinkedIn, Craig's List, local news papers, Indeed

Recruitment will be for 10 staff added during prep period and community health workers (2) to be hired in the prep period but will start in the first month of budget period 1.

The 10 openings being recruited for are: Director (1), care coordinators (2) and RNs (3) , quality (1) and intake coordinator (1)and information systems (1) , support staff position(1) = (10FTE) plus the 2 community health workers starting in budget period 1

Row 7 - Training Expenses

Description of Expense	Cost
included in program budget	
Total Training Expenses (Infrastructure Budget Line 7)	

included in program budget

Row 8 - Retention Expenses

Description of Expense	Cost

	A	B	C	D	E	F	G
199							
200							
201							
202							
203							
204	**Total Retention Expenses**						
205	**(Infrastructure Budget Line 8)**						
206							
207							
208	***Retention expenses will be inluded in future budgets***						
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222							
223	**Community Partner <u>Infrastructure</u> Budget Report - Business Start Up Costs - Prep Budget Period**						
224							
225	**Row 9 - Office Equipment**						
226	Description of Expense	Cost					
227							
228							
229							
230							

	A	B	C	D	E	F	G
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232							
233	**Total Office Equipment**						
234	**(Infrastructure Budget Line 9)**						
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251							
252	**Row 10 - Office Furniture**						
253	Description of Expense	Cost					
254	desks, chairs, files	$ 5,000.00					
255	partitions to define office areas: estimate 15 @$265 each	$ 3,975.00					
256							
257							
258							
259	**Total Office Furniture**	**$ 8,975.00**					
260	**(Infrastructure Budget Line 10)**						
261							
262	***Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were***						

determined:

Office desks, chairs, files for 10 staff hired in prep period. Estimate of $500 per individual. ***Director (1), care coordinators (2) and RNs (3) , quality (1) and intake coordinator (1) and information systems (1) , support staff (1) positions = (10FTE)***

Movable partitions to define office space and provide more privacy 15 at $265 each. These are removeable and not considered capital due to cost and portability .

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Quality Manager RN	$ 61,800.00	1	3	$ 15,450
Intake coordinator	$ 23,790.00	1	1	$ 1,982
Support staff	$ 23,790.00	1	2	$ 3,965
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	3		$ 21,397
	Fringe rate	23.0%	Total Fringe	$ 4,921
			Total Program Staffing including Fringe (Infrastructure Budget Line 12)	**$ 26,318**

Quality manager will coordinate clinical record review, metrics and reporting, setting up quality tracking systems. As an RN, this position will be available, on a limited basis during ramp up, to assist with client assessments.

Intake coordinator will work as part of Brien Center intake team to facilitate intake of CP clients and transitioning to BH direct care services.

Suport staff will provide general office support to office based and outreach staff in Pittsfield and North Adams offices

Row 13 - Other Operational Expenses

Description of Expense	Cost
technical assistance with data analysis and	$ 2,500.00
financial modeling	
Total Other Operational Expenses (Infrastructure Budget Line 13)	**$ 2,500.00**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Estimate of technical consulting time for setting up systems and tracking for data analytics and financial modeling for periods 1-5

10 hours at $250/ hour

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**15.00%**	$ 43,971.00

general administrative, management, IT and fiscal support to the program
updated indirect rate as of 9/30/17 for general administrative, management, IT and fiscal support ; 15.6%, capped at 15% on beudget

	A	B	C	D	E	F	G
357							
358							
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360							
361							

Community Partner Infrastructure Allocation Worksheet

Brien Center - this form is N/A

Infrastructure Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Infrastructure Funding
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 717,500	$ 793,811	$ 415,215	$ 251,970	$ 116,426	$ 2,744,923
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL INVESTMENTS	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	IT Staffing including Fringe	Recruitment & hiring of Information Systems Coordinator	12/01/17	02/15/18	position hired							
Technology	Development and Adaptation of E.H.R/Care Management System	Contracting and implementing eHana care management software	11/05/17	12/15/17	software testing							
Technology	Technology for Service Delivery	Interface with ACO	12/01/17	03/31/18	testing							
Technology												
Workforce Development	Workforce Development Staffing including Fringe	Development and implementation of recruitment plan	12/01/17	03/31/18	implementation & hiring							
Workforce Development	Training Expenses	Development of training plan and materials	01/02/18	03/31/18	material completed and training initiated							
Workforce Development												
Workforce Development												
Business Start Up Costs	Operation Staffing including Fringe	Hiring of Director of Care Coordination	12/01/17	02/01/18	position filled							
Business Start Up Costs	Operation Staffing including Fringe	hiring and training of staff for go live date	01/02/18	05/31/18	staffing operational							
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Office Furniture	set up Pittsfield & North Adams offices	01/15/18	03/31/18	set up completed							
Operational Infrastructure	Other Operational Expenses	Development of policies & procedures	01/15/18	03/31/18	policies & procedures completed							
Operational Infrastructure												
Operational Infrastructure												

BH Community Partner - Staffing Model

Brien Center

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	1025	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	1	*Total management oversight of BH CP*
3	Medical Director		*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs	4	
5	Clinical Care Managers (RN)		*Do not include FTEs listed in line 4*
6	Clinical Care Managers (LPHA)	4	*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders		*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff		*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	4	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)	4	*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists	1	
12	Administrative Support	1	*admin support*
13		1	*IT support*
14			
	Total FTE	20	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1:256	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	1:11	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

The BH CP Director will directly supervise community health workers as well as RNs, Clinical Care Managers, and recovery coaches . Staff numbers represent staffing at end of budget period 1

Section 7.3 Initial DSRIP Participation Plan

A. Executive Summary

1. Goals, Identified Challenges, and Proposed Solutions

The Brien Center for Mental Health and Substance Abuse Services is a community-based, non-profit agency with an over 95-year history of providing a continuum of care for children, adolescents, adults and families with serious and persistent Behavioral Health (BH) disorders. Each year, Brien serves approximately 10,000 Berkshire County residents, including 4,000 children. Our approach to treatment uses a comprehensive care model that incorporates recovery, resiliency, and rehabilitation principles; promotes individual and family choice; is evidence based; and uses family, team, and natural supports that promote stabilization, recovery, and wellness within the person's community setting whenever possible. With 27 locations throughout Berkshire County, treatment and services are accessible to residents. *Brien's model features the same services that the State is seeking to purchase under the Behavioral Health Community Partner (BH CP) Request for Responses (RFR).*

The Brien Center has developed a long-standing collaboration with Berkshire Health System (BHS) and Community Health Program (CHP), both of which are very important to meeting the holistic needs of consumers within our community. Also, we have a long-term partnership with Berkshire Children and Families (BCF) to provide intensive services to children with serious emotional disorders. Brien has collaborated with Berkshire Medical Center (BMC) since 1993, offering the opportunity for care integration that is not otherwise available. Our organizations share psychiatric staff and have woven hospital and community services together, offering a continuum of inpatient psychiatric, detox and Clinical Support Services, crisis care, outpatient therapy and residential and day treatment services.

The Brien Center's ongoing clinical collaboration with BHS, BMC and the Department of Psychiatry and BH, CHP and BCF allows us to provide the full spectrum of BH services in Berkshire County. Our clinical collaboration provides quality care; long-standing and valuable partnerships like these minimizes duplication of services and offers the promise of quality, cost-effective care.

Goals. The Brien Center's goals align closely with the State's goals to:

- Help individuals with Severe Mental Illness (SMI) and/or Substance Use Disorder (SUD) navigate BH care
- Strengthen and enhance access to services for individuals and families through strategic community relationships
- Assist individuals in becoming valued community members by helping them attain meaningful community roles as active participants locally and establish valued relationships
- Employ evidence-based practices and data-driven decision-making process to guide care
- Support Community-First values and SAMHSA recovery principles through a person-centered approach that emphasizes cultural competence and respect
- Address social determinants of health through integrated care delivery

Challenges and Proposed Solutions. We describe challenges and solutions associated with meeting the State's BH CP Contract requirements in the following table.

Challenges	Solutions
Developing Information Technology (IT) solutions that support the unified presentation of assessment data, Person-Centered Treatment Plans (PCTPs) across BH CP, PCPs, Model A ACO Contractors and other stakeholders that support true care integration	Support data integration; Collaborate with ACO Partnership Plans (ACOs) to employ a single Comprehensive Assessment and PCTP
Promoting integrated delivery of medical and BH Care, as well as psychosocial supports	Promote access to primary care for individuals who are BH CP eligible. Develop IT solutions that support care integration.

2. Anticipated Number of Enrollees

The Brien Center currently serves an estimated 1,430 BH CP eligible Enrollees and can support a total of 1,547 within the proposed Pittsfield and Adams Service Area. We are prepared to add capacity over the Contract period. See **Attachment 7.2.A.**

3. Service Areas

The Berkshires is unique in its' relative geographic isolation; the service area truly stands alone. As a result, The Brien Center is submitting this RFR submission to participate with EOHHS as a BH CP for our current Service Areas, Pittsfield and Adams (encompassing Berkshire County), without artificially crossing a geographic barrier to the Connecticut River Valley of Western Massachusetts. We provide services in the geographic area that we know best.

The Brien Center proposes to serve MassHealth Enrollees in the Adams and Pittsfield Service Areas which includes all of Berkshire County; located on the western edge of Massachusetts bordering Vermont to the north, New York to the west and Connecticut to the south. It is the second largest county by land area in the state with a total of 946 square miles of rural countryside.

4. Plans to Operationalize the CP Program

To operationalize the BC CP program, we will engage in the following crucial implementation activities, based on time frames indicated in our Implementation Plan, included in this RFR submission in **Section 7.3.F.**

B. Supporting Populations and Community Engagement

1. Connections to the Community

We meet the needs of Enrollees through a plethora of longstanding connections to a diverse set of organizations described below.

Community Organization	Description of Partnership
Jones (inpatient psych), McGee (detox) and CSS at BMC **MATC and WATC, Highpoint**	Section 35 client referral source to Keenan House for consult before discharge

Community Organization	Description of Partnership
Treatment Center	
MBHP	Clinical collaboration with providers through MBHP training, monthly meetings w/ regional directors
Spectrum Health Services	Referral of clients for methadone treatment if other MAT options are declined/not appropriate
Ad Lib	Assistance with SSI/SSDI, peer counseling, housing, PCA
Advocacy for Access	Assistance with MassHealth
Berkshire Children and Families	Provides CBHI Family Partners; parenting skills development
Berkshire Community College and Mass College of Liberal Arts	Frequent linkage thru case management for post-secondary education purposes—can involve consultation, transport
Berkshire Pathways	Mental Health/clubhouse, employment assistance
DCF	Referrals made to SUD treatment programs for adults and youth
DTA	Assistance with Food Stamps
Elizabeth Freeman Center	Referrals to The Brien Center for females with addiction problems; provide domestic violence services
Mass Rehab Commission	Vocational evaluation, career placement, and assistance with education
N Berkshire Community Coalition	Sharing information to provide services to the community
Adult Learning Center, Adult Basic Education Collaborative	Frequent referrals thru case management and can involve transport, calls, consultation, mutual training
Pittsfield Prevention Partnership-Berkshire United Way	Community-Based SUD collaboration. The Brien Center provides staffing for community activities and is member of the governing board
Railroad Street Youth Project	Provide groups to youth at the program and education
Schools: Pittsfield; Lenox; C. Berkshire; Monument Mountain; Mt Everett; Hoosac; Mt Greylock	The Brien Center staff provide school-based substance abuse prevention services at local schools
Suit Yourself (Goodwill)	Job readiness skills, interview & workplace attire
Pregnancy and Postpartum Support Coalition	Mothers share experiences in access while experiencing perinatal emotional complications
Food Bank, Salvation Army	Emergency groceries; mobile distribution center
Barton's Crossing—ServiceNet	Onsite CSP CM to discuss SOAP and OBOT
Berkshire Housing	Housing needs for unification with family and children
Berkshire and Pittsfield Regional Housing Authorities	Referrals to shelters and assistance with permanent housing
Berkshire District Attorney	Provide free services to victims of OUI and homicide crimes through MOVA grants awarded to The Brien Center
Berkshire House of Corrections	The Brien Center addiction pre-release IOP program M-F
House of Correction /Chicopee	Referrals made to The Brien Center for women being discharged from incarceration and returning to Berkshire County
Mass Alcohol and Substance Abuse Center and Mass Correctional	Referral source of Section 35 clients to The Brien Center's Keenan House—consult before discharge

Community Organization	Description of Partnership
Institution (MCI)	
MA Department of Probation	Referrals, Monitoring of treatment outcomes and progress
Hillcrest Better Breathers	Smoking cessation
Community Health Program	Embedded The Brien Center clinicians in Pittsfield, Lee, Adams and G. Barrington refer patients w SUD to The Brien Center O/P programs
Primary Care/Family Medicine	Primary Care Doctors
Project Empowerment	HIV/AIDS Support, referrals to BH treatment
State Labs Clinic	HIV, Sexually Transmitted Infections, Hepatitis Testing and Treatment
Tapestry Health Systems	Family planning, reproductive health, Narcan overdose training, referrals
Women Infants and Children	Nutritional supports, immunization services, health screening

2. How We Will Grow our Connections to the Community

The Brien Center will leverage and build on existing relationships and collaborations as one means to enhance access, integration, and continuity for Enrollees. One of our organizational goals is to grow our collaborative efforts with community-based organizations over the course of the BH CP Contract.

To meet this goal, we will implement initiatives that address social determinants of health by enhancing our ability to address needs such as housing, food, safety and other issues, breaking down existing silos and delivering integrated care. For example, we participated in BHS' Community Health Needs Assessment to inform efforts to meet the needs of the communities we serve. As we have done, we will continue to work side-by-side with community organizations and stakeholders to find ways to help children and families achieve their recovery goals.

3. Plans to Ensure Staff is Informed of Community Resources

Our plans to inform and update staff include the development of a community resource guide, staff training, and interdisciplinary care team meetings. We will maintain current information on all community resources and regularly update staff regarding this information.

C. Community Partner Supports and Activities

1. Outreach and Active Engagement

a. Planned Strategies for Outreaching to and Engaging with Assigned Enrollees, Including Individuals Homeless and Hard to Reach Individuals

The Brien Center provides key access points to services in the Pittsfield and Adams Service Area. We will identify and engage many Enrollees through our provided services as a part of our daily operations. For these cases, personnel within each agency will work closely with the BH CP Care Coordinator. The Brien Center subscribes to Substance Abuse and Mental Health Service Administration's (SAMSHA) philosophy and approach to locate, outreach and engage Assigned Enrollees who have not otherwise been engaged in services. This philosophy begins with our learning about the Enrollee's current BH provider relationships and the importance of meeting the Enrollee's basic needs. As we initiate contact with the Enrollee, we begin building rapport

and trust, focusing on strategies to connect Enrollees to services without making them feel uncomfortable, judged or threatened. Key outreach strategies are as follows:

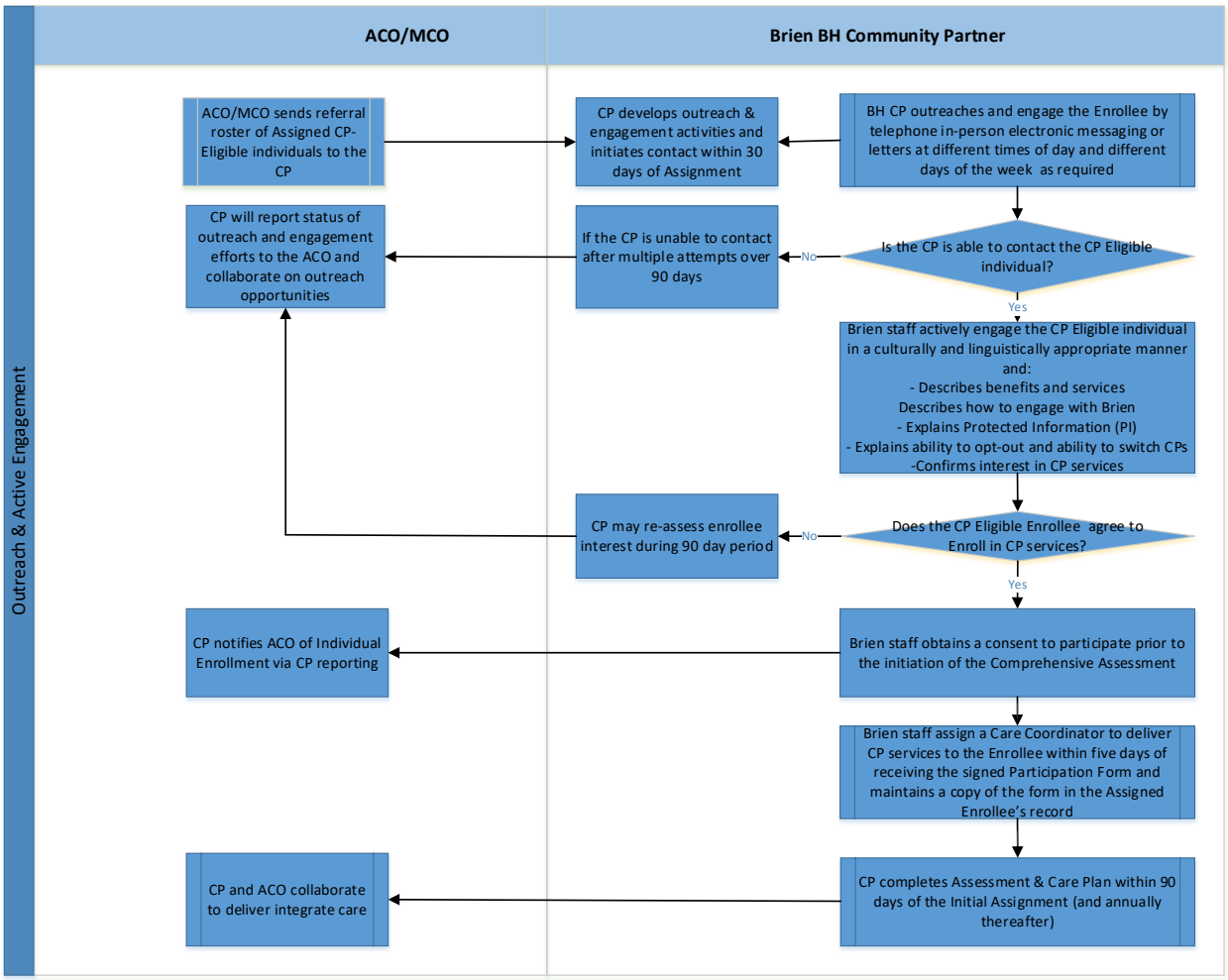
The Brien Center meets the Enrollee at any available location in the community where the individual is personally comfortable, which may include but not be limited to their home, neighborhood locations, tent cities, motels, shelters, or congregate meal sites among other locales. We seek to truly connect with the Enrollee and build trust, regardless of where we physically meet. We feel strongly that asking the Member to select the location that would be most comfortable for them is an important step toward building the Enrollee's confidence in the BH CP and trust. Our knowledge of the Pittsfield and Adams community and culture is a great asset in approaching this important strategy.

Our organization makes the process of building a relationship with the Enrollee as primary and does so by being highly respectful toward Enrollees and their families. We seek to create an open, safe, friendly environment that is trauma-sensitive in which to meet. Moreover, we immediately seek to assess and meet Enrollee's basic needs.

We hire highly qualified, skilled individuals who are trained in motivational interviewing and are very skilled at engaging and interacting with individuals who have SMI and SUD diagnoses. Furthermore, we hire staff who are experienced in serving the target population and understand their needs and preferences that go well beyond cultural and linguistic needs.

The following Figure C.1 illustrates the Outreach and Engagement process.

Figure C.1. Engagement Process



Our primary strategies to outreach and engage Enrollees, including individuals who are homeless, reflect the philosophy and strategies described above. For individuals who are homeless, our efforts notably include direct community outreach in areas where homeless individuals congregate and live, including tent cities, under bridges, in downtown areas, outside shelters.

The Brien Center will employ BH CP Care Coordinators and Community Health Workers to conduct outreach, and connect with, Eligible Enrollees to schedule the first in-person contact, with a minimum of one outreach activity to each assigned Enrollee within one month of receiving an Assignment from the ACO. In practice, we will attempt to reach the Enrollee by phone within less than 30 days of Assignment. While we will normally contact Enrollees in the community, if an Eligible Enrollee is hospitalized, we will attempt to make the first in-person contact during an acute care event at the hospital, taking care to ensure that the Enrollee is comfortable. In this manner, we will proactively participate in the Enrollee's transition of care at the outset of their enrollment. Whenever possible, based on the Enrollee's willingness to meet,

we will meet with the individual face-to-face within the first three calendar months of the Enrollee's assignment. If the Enrollee is not willing to meet, we will continue to identify opportunities to introduce BH CP services. Enrollees will also be able to request assignment to a different staff member within our organization or assignment to a different BH CP organization at any point in time.

We will make every effort to contact Enrollees who cannot be reached telephonically by going to community locations where we know we may locate the individual (e.g., at home, at a congregate meal site). We will make at least three attempts to establish contact and anticipate that we may need to make several attempts to contact an Enrollee to schedule a time and location for an initial meeting.

Our staff will meet with the Enrollee in a location, and at a time that is most comfortable for the individual with a family member or caregiver, if desired by the individual. If agreed to by the Enrollee, we will meet with him/her in their home to obtain insight into the Enrollee's social determinants of health and home safety.

At our initial meeting, The Brien Center staff will provide Enrollees with introductory materials including information regarding the benefits and the design and purpose of BH CP supports. This information will be offered in written and verbal formats and will be available to Enrollees' in their primary preferred language for the most commonly spoken languages among the population served.

We will provide information regarding the BH CP service delivery process to help the Enrollee understand how to engage with our organization and will explain that the Enrollee can opt out of receiving BH CP services at any time. We will further provide information regarding how to reach our website, participate in the Consumer Advisory Board, and contact a BH CP Care Coordinator or Community Health Worker or Community Health Worker.

During the first in-person contact, The Brien Center staff will employ motivational interviewing to understand the Enrollee's health status, their needs and preferences and, their aspirations and/or frustrations with barriers to care delivery that require attention. At a minimum, the Care Coordinator will describe benefits and services, describes how to engage with Greater Lowell BH CP staff, explains Protected Information (PI) and the purpose of this practice; explain the individual's ability to opt-out of BH CP services as well as the ability to switch CP agencies entirely. Ultimately, the Care Coordinator will confirm the Enrollee's interest in CP services and obtain a signed Participation Form, and file it in the Enrollee's records.

After the Participation Form is signed, we will perform the Comprehensive Assessment and work to truly understand the Enrollee's needs and preferences in their primary preferred language with attention to cultural beliefs. We will provide individuals who choose not to enroll with contact information should the individual choose to enroll later, and will be asked if periodic outreach from an advocate is acceptable.

Where possible, and when desired by the Enrollee, the individual who performs the initial contact and assessment will serve as the BH CP Care Coordinator or Community Health Worker

and take a leadership role in delivering services as part of our BH CP team. If the Enrollee prefers a different Care Coordinator or Community Health Worker, another staff member from our organization will be assigned based on the Enrollee's preferences.

b. Planned Strategies for Outreaching to, and Engaging with, Assigned Enrollees with SUDs

We will tailor our approach to outreaching Enrollees with a SUD diagnosis based on his/her readiness to participate in treatment, utilizing a harm reduction approach. We will engage Enrollees with SUD diagnoses by assigning staff with appropriate expertise including cultural and linguistic alignment, and using staff who have lived experience and are in recovery using a process that resembles the contractually required process described above.

2. Comprehensive Assessment and Person-Centered Treatment Planning

a. Process for Conducting Comprehensive Assessments

We place the Enrollee at the center of the assessment and treatment planning processes and constantly engage them to identify their needs, priorities, and preferences. Our assessment process will begin with a review of medical records and any available documentation regarding the Enrollee's needs and condition by our registered nurse, who is a part of our clinical team. Specifically, staff will review the Enrollee's medical history, medical needs, and medications and will summarize them for our BH CP Care Coordinator or Community Health Worker, before completion of the full Comprehensive Assessment. Our Clinical Care Manager will review the final assessment upon completion.

If the Enrollee has an existing relationship with a Primary Care Provider (PCP), state agency care/case managers or other treatment providers, we will engage these key individuals in the Comprehensive Assessment and the PCTP processes at the outset.

The Brien Center's goal is also to leverage any information already collected by the Enrollee's ACO partner. We believe this is important to maintaining a person-centered, efficient process that minimizes duplication and demands on the Enrollee. We are already engaged in conversations with the potential ACO in our geographic area regarding information sharing strategies to inform the Comprehensive Assessment and other processes. We hope to work with the ACO in our Service Area to develop a single integrated assessment that builds on information already obtained from the Enrollee. Gathering the same information from the Enrollee or other sources could be disruptive to the Enrollee as well as wasteful and inefficient.

Ideally, with the Enrollee's permission, we will incorporate any available data from the ACO into the BH CP Comprehensive Assessment. Our Care Coordinator will then meet with the Enrollee to complete the BH Assessment and specifically assess the Enrollee's immediate care needs, current services, personal and familial medical history, medications, health communications skills, existing primary care utilization and emergency department utilization history with a specific focus on BH and SUD needs and preferences.

Our Care Coordinator or Community Health Worker will also reach out to the ACO Care Manager to integrate across physical, BH and other care needs together, in a team-oriented manner. We will participate on the Enrollee's ACO Care Team if possible, with the goal of jointly preparing a truly Comprehensive Assessment.

Following the completion of the Comprehensive Assessment by the Enrollee's Care Team, ACO and other key providers, we will communicate the results of the assessment to the Team and jointly determine implications for on-going care planning.

The Brien Center will use a combination of the Massachusetts Standardized Data Project (MSDP) forms to perform Comprehensive Assessments for BH CP Eligible individuals. We agree to meet all EOHHS requirements pertaining to mandatory data elements mandated in the Model Contract. We will select appropriate forms based on adult, child/adolescent, SMI or SUD status. Our goal is to maximize person-centeredness, minimize duplication and maximize efficiency. We plan to review and discuss the MSDP tools, included as **Attachment 7.3.C** to this RFR submission with local ACOs, prior to sharing our final selection of forms with EOHHS. The attached MSDP forms include: a Comprehensive Assessment for Adults, a Physical Health Assessment (in the event that such information is not available from the ACO); a Child and Adolescent Assessment; and, an Addictive Behavior and Substance Use History Addendum.

b. Process for Conducting Person-Centered Treatment Plans

After the Comprehensive Assessment is completed, our BH CP Care Coordinator will use the assessment data, combined with other available information (e. g. medical records information and other relevant data) to develop the PCTP with the Enrollee. We will seek to develop a truly integrated PCTP that addresses each Enrollee's medical, behavioral, substance use and psychosocial support needs. The Brien Center will employ specialized staff to serve individuals with SUD diagnoses including Recovery Coach Navigators.

The BH CP Care Coordinator and/or Community Health Worker will collaborate with the Enrollee and their family member or informal caregiver to create a truly person-centered plan that reflects the Enrollee's needs, preferences, and goals. We will encourage the Enrollee to take a lead role and making sure they can develop their PCTP goals.

As stated above, we will seek to participate in the Enrollee's ACO Care Team or Interdisciplinary Care Team (ICT) meeting and, will consistently invite the ACO to participate in BH CP Enrollee care plan meetings. Regardless of who requests the meeting, a Brien Center Care Coordinator will seek to lead an integrated discussion of BH CP needs, rather than requiring the Enrollee to attend separate meetings with their ACO and our BH CP staff.

If the ACO does not plan to hold a meeting to discuss the Enrollee's PCTP, we will hold a separate meeting to discuss the Enrollee's BH needs and will invite the ACO or MCO to participate. If the Enrollee prefers a separate meeting specifically to discuss their BH needs, we will offer a session with the Enrollee's BH CP Care Coordinator or Community Health Worker and other BH CP Care Team members as requested. Regardless of when this initial meeting is held, we will complete the PCTP within three months of the Enrollee's assignment to The Brien Center.

The BH CP PCTP will include, but is not limited to: Enrollee goals and objectives, specific action steps to achieve goals, a method for tracking goal progress, referral needs to obtain care and services, educational needs, and any other necessary information. PCTPs may also include a crisis plan, especially for individuals with BH needs with a history of crisis service utilization. The PCPT will include actionable steps, responsible parties and timeframes for implementation.

Planned processes for documenting the Person-Centered Treatment Plan. To document the Enrollee's PCTP, The Brien Center plans to use Fallon Health Plan's TruCare system, if they are selected as an ACO. Access to TruCare will allow The Brien Center and the ACO (if Fallon is selected) to share an interoperable record fully.

Planned processes for updating the Person-Centered Treatment Plan. The Brien Center Care Coordinator will update the PCTP in collaboration with the Enrollee, their family member/caregiver, the ACO and other key stakeholders identified by the Enrollee. Our BH CP Care Coordinator will be responsible for updating PCTPs at any major change in the Enrollee's condition (e.g., loss of housing, loss of informal caregiver, BH crisis, new BH diagnosis, BH or medical hospitalization, multiple ED visits) progress toward treatment goals, a decline in functioning, or transition between levels of care. If the Enrollee's quality of life is not improving or the Enrollee feels that the plan needs an update, we will also update the PCTP.

The BH CP Care Coordinator or Community Health Worker will share PCTP updates with the Care Team within the Enrollee's ACO and, internally within the BH CP. Recognizing that Enrollee's needs are fluid, our BH CP Care Coordinator or Community Health Worker will review the PCTP and the Enrollee's progress during each interaction and inform key stakeholders as necessary and appropriate while respecting the Enrollee's privacy and wishes.

The Brien Center will complete thorough re-assessments which will include, but are not be limited to: updates that review past progress toward goals, health status, future goals, monitoring of compliance with the PCTP, recommended follow-up and a complete update to the PCTP. Each time a re-assessment occurs, or if the PCTP changes because of a review, we will update and distribute the PCTP appropriately. We will conduct reassessments and update to the PCTP at least every six months and following a change in Enrollee status that is self-limiting, impacts their health status and requires a review.

We will develop a process that is consistent with the creation of the original PCTP where the Enrollee and the PCP approve the PCTP before implementation. We will further review and provide a copy of the Plan to the Enrollee and the PCP upon completion.

Ensuring the Assigned Enrollee and PCP or PCP Designee approve the PCTP**.** Ideally, the PCTP will be developed by the BH CP with input from the ACO ICT. The BH CP Care Coordinator will review the PCTP and other information with the Enrollee including but not limited to, the Enrollee's right to appeal any denial, termination, suspension or reduction in services or any change in providers, services or medications included in the PCTP. They will inform the Enrollee of their right to approve the PCTP and make sure that the Enrollee approves the PCTP. The Brien Center will work to obtain sign-off from the PCP who will receive a copy of the PCTP upon completion.

Upon Enrollee and PCP approval of the PCTP, the BH CP will provide the Enrollee and the full team with a copy. The Brien Center will coordinate care with the PCP and Care Team based on the PCTP.

If the ACO is unable to develop the PCTP directly in collaboration with the Enrollee and the BH CP, the BH CP Care Coordinator or Community Health Worker will share the PCTP with the Assigned Enrollee. The PCPT will be reviewed with the Enrollee's PCP to obtain sign-off, following a complete review by The Brien Center's registered nurse who will be responsible for PCPT sign-off.

3. Care Coordination and Care Management

a. Identifying All Stakeholders Involved in an Enrollee's Care

The Brien Center will identify all stakeholders involved in the Enrollee's care through multiple methods. First and foremost, we will ask the Enrollee which individuals they most want to be involved in their ICT. Our BH CP Care Coordinator or Community Health Worker will contact the individuals' PCP, involved State agencies and community-based organizations who are involved in the Enrollee's care. The Brien Center staff will also contact the Enrollee's ACO to determine what care management efforts are underway so that care is fully integrated and coordinated and, no duplication of service delivery occurs.

The Enrollee's Care Coordinator will assemble an ICT that includes, but is not limited to: the PCP, The Brien Center's Clinical Care Manager, the Enrollees' Care Coordinator and Community Health Worker, and their BH clinician and others as appropriate (e.g., family, caregivers, advocates, state agency staff or other care managers). We will also include LTSS providers who are aware of the Enrollee's LTSS needs and preferences and will counsel the Enrollee regarding LTSS options, including a choice of at least two LTSS service providers. Likewise, our BH CP Care Manager will facilitate access to, and the delivery of LTSS for eligible individuals and will assist in servicer navigation.

b. Exchanging Information with Such Stakeholders

The Brien Center will share information with stakeholders verbally and in writing. We will hold community meetings and visit key community partners to explain the use of BH CP services. Each time we integrate care for an Enrollee, we will educate stakeholders regarding the relationship between BH CP services and the services that they provide.

c. Identifying and Organizing Members of the Enrollee' Care Team

The Brien Center describes our process to identify members of the Enrollee's Care Team in response 7.3.C.3.a. above. Our goal is to be available to the ACO or MCO's team and/or to facilitate a meeting of the Enrollee's full team (e.g., including not just our BH CP Care Team but the entire ICT, including the Enrollee and family or caregivers, if appropriate) to participate in the development and implementation of a fully integrated person-centered assessment and PCTP for each BH CP eligible Assigned Enrollee.

d. Ensuring Effective Ongoing Communication Across All Stakeholders

The Brien Center will ensure effective ongoing communication across stakeholders through multiple means. First, we will maintain close contact with the Enrollee to ensure that their needs and preferences are met. Also, we will regularly communicate with the Enrollees' PCP and key agency and community-based caregivers to ensure coordination and integration. While we plan to participate in, or hold, an ICT meeting to initially create a PCTP to meet the Enrollee's needs, we will reach out to key stakeholders telephonically as needed and initiate ICT meetings when appropriate and necessary.

To make sure that Enrollee's needs and preferences are addressed, we will share the PCTP with the Enrollee and their family or informal caregiver, the Enrollee's PCP, specialist and other providers or key stakeholders. We will further coordinate medical, prenatal, outpatient BH and preventative care reminders with the ACO. We will assist Enrollees in scheduling medical and BH appointments and, will conduct follow-up in collaboration with the ACO or MCO, to ensure that appointments are kept and that the Enrollee's situation has not changed.

The Brien Center will employ Fallon's TruCare Care Management System to share information with PCPs, Fallon and other providers. Fallon has agreed to grant access to TruCare to any individual who is responsible for managing an Enrollee's care; as a result, information sharing is simplified. The Brien Center will look at additional solutions to promote technology interoperability to enhance our connectivity and sustainability as a BH CP provider.

4. Care Transitions

The Brien Center is aware that transitions of care represent an important opportunity to promote quality, Enrollee satisfaction and cost-effectiveness of care delivery. We will deliver transitional services to assist the Enrollee in effectively transitioning from a hospital, skilled nursing facility or rehabilitation stay to their chosen living situation. In establishing a strong transition to the community, we will further seek to proactively plan services and supports and avoid or decrease unnecessary Emergency Department (ED) visits or hospitalizations. Our goal is to support the Enrollee's ability to live successfully in the community, in the setting of their choice.

We will participate, in collaboration with the ACO or MCO and other providers, in transition planning before an inpatient discharge. We will maintain strong relationships with the ACO or MCO, participate in discharge planning meetings and follow-up with hospitalized Enrollees through a face-to-face visit that will occur within three business days following discharge. We feel strongly that visits to Enrollees who were recently hospitalized must be coordinated with the ACO or MCO so as not to overwhelm them.

As part of the transitions process, we will update the PCTP and coordinate clinical and support services as needed. We will further assist the Enrollee to access additional supports from providers (with warm hand-offs as needed and appropriate) and follow-up to ensure that the Enrollee attends the appointment. Where Enrollee's miss appointments, we will address any barriers to care, such as providing transportation assistance.

5. Medication Reconciliation

The Brien Center adheres to evidence-based practices in all aspects of care management, transition planning, and medication administration. Our registered nurse, an active member of the Enrollee's Care Team, will perform medication reconciliation as part of transition planning upon discharge, and at appropriate times when delivering BH CP services. We will contact the Enrollee's PCP to verify medication orders and will review with the Enrollee, whether all prescriptions were filled appropriately.

Our BH CP Care Coordinator or Community Health Worker will review medications during the transition visit within three days of discharge and will assist the Enrollee in adhering to their medication regimen. The BH CP Care Coordinator or Community Health Worker and the registered nurse will identify additional supports to assist the Enrollee with taking their medications appropriately. If the Enrollee is in a Medication Assistance Program (MAP) the BH CP will work with the Enrollee's PCP to update the medication order forms with the MAP provider.

6. Health and Wellness Coaching

a. Health and Wellness Education, Coaching and Health Promotion Programs

The Brien Center believes that evidence-based health and wellness promotion activities are an integral component of improving the overall wellness and recovery for individuals with SMI.

As described in our response to Section 7.2.D.2, we have significant experience providing health and wellness education to our Enrollees. For example, we maintain an active Health and Wellness Committee, provide staff training in Executive Order 509 nutrition standards with programs offered related to nutrition, connect Enrollees to tobacco cessation programs, and educate Enrollees on self-management of chronic medical conditions. We will leverage our experience and existing processes to establish a comprehensive, evidence-based Health and Wellness program that meets or exceeds the requirements detailed in Section 2.3.F of RFR Attachment A.

In our experience, some Enrollees have a greater need for health and wellness education, coaching, and intervention than others. In some cases, general educational information will suffice. In others, such as when an Enrollee is significantly overweight, sedentary, or is struggling with tobacco use, more intensive interventions may be required. For these Enrollees, we will offer wellness programs of longer duration (three or more months), which combine education and activity, and incorporate both nutrition and physical exercise are more likely to be effective than are programs of shorter duration, those focusing only one factor (e.g., nutrition or exercise), or unstructured, education-only programs. As a BH CP, we will establish collaborative Health and Wellness programs with ACOs.

b. Methods for Ensuring the Engaged Enrollee's Goals for the Health and Wellness Programs Are Recorded and Tracked

As part of the Comprehensive Assessment, we will evaluate the Enrollee's need for Health and Wellness information, coaching, or other interventions. We will identify any high-risk behaviors,

including poor nutrition, overweight or obesity, lack of exercise, and other risk factors and share this information with the Care Team, and the Enrollee's ACO. The Enrollee's self-identified goals and objectives for addressing these needs will be documented in the Enrollee's PCTP. The Care Team will monitor Enrollee's participation in recommended Health and Wellness program(s), and periodic updates will be provided to the Enrollee's ACO Care Manager or Care Management Team.

7. Connection to Community and Social Services

a. Plans to Evaluate Engaged Enrollees for Social Service Needs

The Brien Center employs a person-centered approach that considers the total care needs of Enrollees with SMI or SUD. As a BH CP, we will foster an integrated system of care by collaborating with medical providers, Care Managers, ACOs, and other stakeholders, beginning with a Comprehensive Assessment to identify, among other needs, social service needs that can be met by social services and supports agencies.

Our assessment tool, which will be approved by EOHHS before use, will assess such needs as housing, utility assistance, social and cultural engagement, employment services, transportation, child care, food and nutrition supports, physical security, and any additional Flexible Supports that an ACO partner identifies.

As described in response to Section 7.3.B. above, The Brien Center's has long-standing relationships with community and social service agencies in our service area and will leverage these relationships to ensure Enrollee access to needed supports and Flexible Services.

b. Ensuring Care Coordinators are Familiar with a Wide Breadth of Social Services and Supports, and Providers of These Supports

The Brien Center currently has processes in place to refer to and coordinate with community services providers and social service agencies. We will use these existing processes to facilitate ongoing communication and information-sharing and ensure that Enrollees have timely access to needed community supports.

Our formal current and planned approaches include:

- Developing comprehensive referral and community resource guides for Engaged Enrollees and ACO staff
- Appointing dedicated points of contact for ACOs and MCOs
- Executing memoranda of understanding with providers and community organizations regarding the delivery and coordination of services
- Appointing liaisons to foster relationships and communication with community agencies

c. Planned Strategies for Collaborating with ACOs to Recommend Flexible Services

We will jointly develop processes and procedures with ACOs in our service area to coordinate access to Flexible Supports authorized by the ACO. Care Managers will work with ACO Care Managers for Engaged Enrollees to identify supports (as documented and authorized by the

ACO) and jointly establish a plan for providing or arranging for them (as appropriate). These services will be included in the Enrollee's PCTP and monitored by the Care Team. Specific strategies for collaborating with ACOs and MCOs include:

- Upon the execution of the partnership, we will orient the ACO to our organization, services provided or facilitated, structure and operations of our Care Team model, and provide contact information
- Establish and facilitate a joint Care Coordination Planning Committee to develop processes and procedures to ensure communication and collaboration between the two organizations' care management teams
- Establish and maintain periodic joint care management meetings (telephonic, WebEx, face-to-face) to ensure appropriate communication, collaboration, follow-up and accountability
- Develop and maintain a common community resource directory for use by Enrollees and staff
- Conduct joint training (initial and periodic) for care management, care coordination staff
- To the extent allowed by the Enrollee, share care plans, progress reports, status reports, and other pertinent information about Engaged Enrollees with the ACO.

D. Innovative technologies for service delivery

The Brien Center intends to partner with eHana to deploy a care management platform technology to meet or exceed BH CP program requirements in conjunction with our existing EHR and billing system. This will include forms, workflows, processes, reports, and data extracts:

- Tracking Enrollee assignment, engagement, disengagement, and overall capacity
- Capturing appropriate signatures and document approvals
- Surfacing alerts, reminders, and tasks as necessary to prompt Care Team action
- Tracking enrollee events, admissions, referrals, and prompting for necessary follow-up
- Tracking, reporting, and billing Qualifying Activities to EOHHS in specified formats

Care Coordination – The Brien Center will leverage current and future tools based on eHana's technology platform to support effective communication across all stakeholders including, eHana Secure Care Team Messaging, enrollee tagging, QuickNotes, Notifications, and chart exports; and anticipates adopting other technologies (Enrollee Portal, Real-Time Care Team Chat, advanced interoperability) as necessary to effectively coordinate care. We anticipate that eHana will have an information exchange with The Brien Center's ICentrix software.

Mobile Enrollee Engagement Technologies – The Brien Center anticipates deploying mobile apps, synchronized with the centralized care management platform, to be used by Care Coordinators to identify Enrollees requiring outreach, access contact information, and document services.

Social Outreach and Engagement - We are exploring the use of social networking tools, such as Facebook Messenger to engage with Enrollees. Techniques could include leveraging Facebook's Messenger Platform Application Programming Interface (API) to supply Enrollees (or their authorized representatives) with the Contractor's chat name as well as a unique code, which would automatically associate their Facebook Messenger account with their care management

record. Enrollees or their representatives could then outreach to the Care Team at any time via the Messenger app already installed on their phone, notifying their team and prompting engagement in real-time (providing appropriate consents were in place, and with necessary checks to ensure no PHI was exchanged).

System Security and Access Controls – The Brien Center intends to follow the industry-standard best practice to comply with HIPAA requirements restricting unnecessary access to or disclosure of protected health information.

EOHHS Billing - Qualifying Activities/CP Support Services will be tracked in the care management platform and appropriate rules applied (ensuring the minimum necessary number of activities in the billing timeframe). Billing transactions will be batched and submitted in a format to be specified by EOHHS. The Brien Center anticipates billing requirements will bear a resemblance to those of the DMH Community Based Flexible Supports (CBFS) program, which both The Brien Center and eHana have significant experience managing.

E. Personnel and staffing

1. Organizational Chart

We provide our organizational chart as **Attachment 7.3.E-1**, identifying personnel who will be assigned to accomplish the Contractor responsibilities described in Attachment A of the RFR.

2. Sample Staffing Model

We propose serving 1,547 BH CP Eligible Enrollees within our overall Service Area, as detailed in Attachment D of the RFR. Our staffing model will include the following positions and number of full-time equivalents (FTEs).

Positions	FTEs
Administration	**9.5**
Chief Executive Officer	1
Vice President, Administration, and Finance	1
Vice President, Service Operations	1
Medical Director	1
Director of Care Coordination	1
Director of Compliance, Quality, and Nursing	1
Director of IT Operations	1
Information Systems Coordinator	1
Support Staff	.5
Billing Manager	1
Supervisors	**3**
Quality Manager/Compliance (RN-level)	1
Senior Care Coordinator (to supervise care managers, as # eligible enrollees increase)	2
Care Management	**6**

Nurse Care Manager	6
Care Coordination	13
Intake Coordinator	1
Care Coordinator (licensed clinicians--2 with SUD specialty)	3
Community Health Worker	5
Recovery Coach Care Coordinator or Community Health Worker	4
TOTAL	31.5

3. Recruitment Plans, Including Timelines to Recruit Staff

The Brien Center will recruit staff during "Year O," staffing up to develop and implement the BH CP initiative before the implementation date. Our goal is to bring staff on in a manner that is consistent with our Year O budget and staffing. Job descriptions are provided as **Attachment 7.3.E-2.**

4. Recruiting and Hiring Staff from the Cultural and Linguistic Communities They Intend to Serve

The Brien Center is committed to ensuring that staff is representative of the communities we serve. We recognize that "culture" encompasses more than linguistic diversity, and includes racial or ethnic background, national origin, immigration/refugee experience, physical or mental disability, gender and gender identity, and sexual orientation.

To that end, we take care to ensure that our providers, staff, and others are responsive to the linguistic, cultural, ethnic, or other unique needs of all Enrollees. We will assess our current capacity and competencies through an initial survey of provider and staff about Community Partner Supports and cultural diversity. We will also use existing community needs assessments and studies, and will work with our ACO partner to maintain ongoing demographic, cultural, and epidemiological profile of the community. This information will be used to identify both hiring priorities and training needs to increase sensitivity to the needs of individuals from different cultural and ethnic backgrounds.

We will work closely with community-based organizations (e.g., Multicultural Bridge, immigrant and refugee coalitions, advocacy coalitions, LGBTQ advocacy agencies) to identify and leverage opportunities for targeted recruitment activities. We will also partner with ACOs and MCOs to conduct job fairs in specific communities and in languages other than English (where possible).

However, we recognize that recruitment of a diverse behavioral health workforce, particularly for substance use treatment, is a nationwide challenge with numerous systemic barriers that will be difficult to overcome. To that end, we will evaluate the possibility of using DSRIP funds for short-term workforce development strategies (for example, signing bonuses for employees from underrepresented communities). We will also implement a longer-term initiative to review and potentially augment our staff retention programs through ongoing career development, educational assistance, ongoing on-going licensing and credentialing opportunities, and leadership training.

5. Proposed Training, Orientation Plans and Modules for Staff

The Brien Center's training programs are designed to provide staff with an understanding and awareness of the needs of Enrollees with SMI or SUD, available BH CP supports, social services and supports available in the community, and strategies for delivering culturally competent care. We will train Care Teams and other key staff on these topics by enhancing our existing training modules. We will provide refresher training, as well as updated training on best practices at least annually. We will finalize training modules and training schedules before the contract effective date. Below are examples of potential training modules:

Listing of Proposed Training Modules	
Understanding and awareness of the needs of high-utilizing individuals with SMI or SUD	• Chronic Illnesses and Serious Mental Illness/SUD • Recovery and Resiliency • Intellectual, Cognitive, and Developmental Disabilities • LTSS Services: What are LTSS Services, Who Provides them, and How Do We Work Collaboratively?
Understanding Community Partner Supports	• Scope of services • Partnership and Collaboration with ACOs/MCOs • Comprehensive Assessment and Treatment Plan • Flexible Service: Resources, Referral, Follow-up • Collaboration and Communication with community agencies
Cultural Perspectives – Recognizing sensitivities to different cultures, religions, values, and backgrounds	• The Impact of Culture on Health and Health Care (with focus on SMI/SUD) • Health Disparities • Culturally Competent Behavioral Health Care Delivery • The LGBTQ Community

We will seek to partner with the ACO to hold periodic conferences for Enrollees, staff, advocates, BH-CPs, LTSS-CPs, social service and community agencies to enhance their knowledge through sessions delivered by Subject Matter Experts (including experts from the ACOs, MCOs and Independent Living Centers).

We will facilitate staff training by 1) making work hours available for staff to participate on a mandatory basis; 2) tracking participation electronically through a learning management system (LMS); 3) enabling online evaluations and scoring; and 4) providing resource guides and training materials to reinforce learning.

Whenever possible, we will work with ACOs to develop and deliver training on topics of mutual and common interest, such as care coordination strategies, community collaboration, and cultural competence.

We will incorporate existing MassHealth training and resources into staff training and material, encourage staff to attend MassHealth training forums and ensure staff interacting with Enrollees with BH needs complete required training.

6. Description of Staff Retention Strategy

As referenced above, there are systemic challenges and barriers to recruiting and retaining qualified, trained and experienced staff. We believe that addressing these challenges requires a long-range, comprehensive, multi-pronged strategy, including ongoing career development, educational assistance, ongoing on-going licensing and credentialing opportunities, and leadership training.

In the short term, we will explore using DSRIP funds for defined workforce development initiatives, including staff retention efforts. We propose to collaborate with other BH CPs, and ACOs to explore opportunities to develop and implement staff retention programs, including professional development. Potential areas of focus include:

- Encouraging staff to earn degrees in higher education and professional credentials
- Providing leadership training and management skills development training to support staff who seek to advance in their careers
- Providing on-going opportunities for continuing education for licensing and credentialing

We recognize that raising salary levels and benefits will likely result in better retention, but we do not believe that the current environment will allow for this. However, there are additional benefits that can also aid in retention by improving staff experience and morale. These include:

- Fostering an enhanced sense of ownership and accountability among staff by expanding our existing mechanisms to solicit, obtain, and incorporate (to the extent appropriate) staff input into program development, administration, and management
- Cultivating a supportive organizational culture by providing more focused and personalized management, supervision, and mentoring
- Exploring opportunities to reduce administrative burden by streamlining recordkeeping and other documentation requirements, and
- Exploring and implementing creative work allocation and scheduling to allow staff to achieve a healthy work-life balance

F. Implementation Plan and Timeline

Implementation timelines for the Preparation Budget Period and each subsequent Budget Period are provided in Attachment 7.3.F.

G. Budget Report and Budget Narrative

We provide our completed Budget Report and Budget Narrative in Attachments 7.3.G-1 and 7.3.G-2 respectively.

H. Sustainability

The Brien Center will sustainably fund the proposed infrastructure, capacity building investments, and BH CP support services during the Contract Term and following the initial Contract Term through:

- DSRIP Dollars (initial investment and ongoing funds distribution associated with volume
- Shared savings initiatives developed over time with the ACOs/MCOs
- The ability to sell services to MCOs for non-CP eligible individuals who can benefit from CP services to manage the Total Cost of Care for more Enrollees
- Managing fixed costs associated with IT, licensing, fees and general expenditures over time
- Identifying and developing new services for ACO, MCO, and commercially enrolled individuals to help individuals live independently in the community, decreasing the total cost of care associated with avoidable hospital utilization.

I. Quality Management and Performance Monitoring

1. Quality Improvement Program

The Brien Center will build on our existing Quality Management and Quality Improvement (QM/QI) Program to manage all QM/QI functions for any Contract that may arise from this BH CP RFR submission.

Our QM/QI program, which supports our mission, will measure and improve: clinical quality of care; care coordination; access and availability; continuity; and Enrollee experience. Through our QM/QI program, we will apply a data-driven, evidence-based approach to service delivery and analyze and compare data against internal, local, and state benchmarks to identify opportunities for improvement. Our QM/QI program will establish goals, processes, and include an interdisciplinary committee structure that includes Enrollees and family members and representatives.

Applying Principles of Continuous Quality Improvement

The Brien Center's QM/QI Program will be based on continuous monitoring of quality performance measure indicators, clinical practice guidelines and activities. Our goal is to deliver quality care that helps Enrollees maintain and improve health and wellness. Our objectives are to: improve clinical quality; improve coordination of care; improve access to services; and, enhance all aspects of the Enrollee experience. We will achieve our goal and objectives by relying on data-driven decision making, evidence-based practices, and expert advice – all of which will be used to drive improvement. These goals will form the basis of our QM/QI program and provide areas of focus that drive our improvement strategies. We will work to improve care continuously by:

- Using data to identify and address anomalies in care and outcomes
- Developing interventions to ensure that goals are achieved
- Completing objective measurement processes and implementing improvement initiatives

The information used for quality monitoring and improvement derives from several sources including but not limited to: medical record review, Enrollee and/or provider complaints, utilization review, and survey data.

The QM/QI Program will define: clear assignment of roles and responsibilities to the governance functions and staff within the Center; create performance benchmarks in alignment with

program goals and contractual requirements; and Enrollee satisfaction measures. Further, the program will include meaningful roles for Enrollees and their families in QM/QI activities on advisory councils; monitoring processes to review medical record-based studies; and, plans to monitor Care Management service delivery. Using a continuous quality improvement approach, we will compare our outcome results to prior year results to assess our performance in meeting goals, and advance performance by establishing outcome objectives for the next year.

QM/QI Plan

Our QM/QI Plan and Annual Work Plan will constitute the blueprint for all quality goals and describe the activities that we will undertake to address all contractual QM/QI requirements. As outlined in the QM/QI Plan, we will collect and analyze qualitative and quantitative data to drive quality improvement initiatives. The QM/QI Plan will be a responsive, dynamic document and we will continually update it based on stakeholder input and data analysis. We will also maintain an Annual Quality Workplan that delineates a core set of performance metrics and is updated based on the annual review of systems. The Work Plan will define strategies to address priorities outlined in the QM/QI Plan.

Annually, we will conduct a comprehensive program assessment that examines QM/QI program effectiveness, service utilization, cost, quality data, the prior year's outcomes, and compliance with contractual requirements. Progress toward goals will be reported to the Quality Committee, which will determine opportunities for improvement, design interventions, and track the effectiveness of interventions. In this way, we will ensure our QM/QI program is relevant to the population we serve and results in better Enrollee care.

2. Description of at Least One Quality Initiative The Brien Center Proposes to Undertake in Budget Period 1

The Brien Center is committed to improving Enrollee care by enhancing the quality and integration of services we provide. To that end, we propose to implement a quality initiative related to enhancing Care Coordination and Care Management for high-cost, high-risk Enrollees served by contracted MassHealth ACOs. Specifically, we propose to increase the number of BH CP eligible Enrollees who receive fully integrated services in collaboration with an ACO Partner.

Description

For this QM/QI effort, The Brien Center will develop a process with at least one ACO Partner in our geographic area to jointly conduct a Comprehensive Assessment and to develop a single PCTP. All BH CP Enrollees will receive a Comprehensive Assessment and a PCTP; however, for this QI/QM initiative, we will develop a joint PCTP for at least 50% of the Engaged Enrollees who are jointly served by the BH CP and the ACO. The PCTP will be developed by a Care Team that includes the PCP, family and/or informal caregivers, the ACO Care Manager, the BH CP Care Coordinator and any other individuals whom the Enrollee wishes to participate on the Team.

The Brien Center will work with the ACO to implement a person-centered process where data elements that are required by both Comprehensive Assessments are shared, based on which organization obtains the data first, with the Enrollee's permission. Then, we will either

participate on the ACO's Care Team or, we will invite the ACO to participate in a BH CP Care Team. The Brien Center will develop and document an integrated PCTP in collaboration with the ACO. We will then implement the PCTP and continue to work with the ACO to integrate care.

Target Population

The target population for this initiative includes high-risk, high-cost actively engaged ACO Enrollees who are BH CP eligible.

Measures for Success

We will measure the percentage of actively engaged BH CP eligible Enrollees who are jointly served by the ACO and BH CP for whom the BH CP provides a fully integrated Comprehensive Assessment and PCTP (divided by the total number of actively engaged BH CP eligible individuals). For the first year of the Contract, we propose a 60 percent success rate for jointly developed Assessments and PCTPs; however, all Enrollees will receive an Assessment and a PCTP.

We will implement this initiative in Budget Period 1 and continuously evaluate the effectiveness of this initiative in meeting established goals. Data related to this initiative will be continuously monitored through our Quality Committee structure as described below.

3. Functions of The Brien Center's Quality Committee

The Brien Center will maintain a multidisciplinary committee structure that drives quality improvement through the review of quality data and will incorporate Enrollee and family feedback. Our Quality Committee will meet monthly and be responsible for: 1) identifying quality improvement opportunities; 2) finalizing intervention strategies to improve quality and cost-effectiveness; 3) establishing timeframes for interventions; and 4) tracking the effectiveness of interventions and making modifications to improvement strategies, as needed. The Quality Committee will report to the Governing Board.

Our Committee structure will include:

- Governing Board: The Governing Board will serve as the decision-making authority for the BH CP and provide strategic direction and programmatic oversight.
- Quality Committee: Performance data will be reported to the Quality Committee, which will analyze data against program goals and develop performance improvement initiatives. This committee will meet monthly and be chaired by The Brien Center Executive Director.
- Consumer Advisory Board: The Consumer Advisory Board will be responsible for ensuring that services delivered are consistent with our mission and values, identifying service gaps and solutions to address them, and gathering direct feedback regarding service delivery from individuals served and direct care workers. Information gathered from our Consumer Advisory Board will be used to inform changes in policy and practice.

J. Coordination with ACOs and MCOs

The Brien Center is aware that an essential part of the success of the BH CP contract relies on our shared ability to coordinate with ACOs and MCOs in our service area. We believe that

Enrollees will be best served by sharing a single, modular Comprehensive Assessment and PCTP and communicating complete, up-to-date integrated Enrollee information across organizations, including state agencies and community-based organizations. In our experience, information-sharing is crucial to the delivery of integrated care management and represents an opportunity to achieve savings on infrastructure and IT resources.

At the outset, we will a have a compliant, functioning solution that supports care integration; however, over time, our desire is to have a fully interoperable system capable of supporting shared assessments, care plans, reporting and quality management functions. We believe that creating a fully integrated IT system is the State's responsibility; however, we are already collaborating with ACO and MCO partners in our service area and will do everything possible to support such collaboration.

1. Communicating Our Skills, Expertise, and Value to Potential ACOs and MCOs

The Brien Center has already initiated discussions with ACOs and MCOs in our service area to discuss our skills, expertise, and value to care integration efforts. We will continue these discussions over the next several months as BH CP, LTSS CP, ACO and MCO contracts are awarded by EOHHS. We are communicating and will continue to educate ACOs and MCOs regarding:

- Shared responsibility in caring for MassHealth Enrollees with the greatest needs and level of risk, given their SMI and/or SUD diagnosis.
  - The contribution that The Brien Center can make to delivering quality care for Enrollees with SMI and SUD diagnoses. We will impact integration, Enrollee satisfaction and total cost of care among other measures, all of which will be vitally important to Enrollees, our organization, ACOS and MCOs, and our joint efforts to deliver care.
- The breadth and depth of BH CP services available to eligible Enrollees. For example, we will discuss the specialized nature of the BH CP component of the Comprehensive Assessment, the PCTP, and ongoing care plan implementation and monitoring.
- The importance of primary care delivery for individuals with SMI and SUD, many of whom go without primary care services for a variety of reasons. One of our goals is to ensure that Enrollees with significant BH diagnoses receive primary care services, given that individuals with SMI diagnoses die, on average, 25 years earlier than their peers without an SMI diagnosis.
- Collaborative strategies to integrate primary care and BH care for BH CP eligible individuals in the assessment, care planning, and care delivery process.

2. Branding and Marketing Plans Regarding Relationship with ACOs and MCOs

The Brien Center's Marketing and Branding plans will be guided by MassHealth policies and procedures, which clearly prohibit MassHealth vendors from directly marketing to Enrollees. Our

priority will be to serve Assigned Enrollees who have a pre-existing relationship with our organization.

For Marketing and Branding, we plan to take an approach that is educationally focused on health and wellness in the community including:

- Developing an awareness campaign of the value of BH CP services for Enrollees with significant BH needs. Our goal is to enhance access to services by making materials available to ACOs and MCOs in the most commonly spoken languages in the service area and distributing them to Enrollees as part of the enrollment process.
- Educating ACO and MCO partners regarding our services and the benefits of our integrated approach.

3. Strategy to Engage and Collaborate with Multiple ACOs and MCOs

The Brien Center will provide information and reach out to develop relationships with all ACO and MCO partners in the Service Areas for which this bid applies.

4. Strategy for Conflict Resolution

The Brien Center will partner closely with ACOs and MCOs in the Service Area to serve the needs of BH CP eligible Enrollees. We will leverage and build upon the strengths that our organization brings to this engagement. While we do not anticipate disagreements in areas of shared responsibility, we recognize that differences of opinion may arise, specifically related to care management decisions that affect Enrollees or, the way the Contract is managed. Our mutual intention is to resolve those disagreements promptly that causes no harm to Enrollees and maintains compliance with the terms of the contract.

In general, the forum for resolving disagreements and conflicts between the BH CP and the ACO or MCO will be addressed at the Board of Directors. Going forward, we will create a structured process to escalate issues of significant financial impact to the ACO or MCO, or other major strategic issues.

Community Partner Program Budget Report

Community Counseling of Bristol County, Inc.

Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Estimated Enrollees- Start of Period (All Enrollees)		0	942	2,432	2,432	2,432	
Estimated Enrollees - End of Period (All Enrollees)		942	2,432	2,432	2,432	2,432	
Estimated Enrollees - Monthly Average (excl CBFS enrollees)		784	1,772	2,432	2,432	2,432	
Estimated Enrollees - Monthly Average (CBFS enrollees only)		212	212	212	212	212	
Estimated Program Revenue (excl CBFS enrollees)		$ 987,840	$ 3,827,520	$ 5,253,120	$ 5,253,120	$ 5,253,120	$ 20,574,720
Estimated Program Revenue (CBFS enrollees only)		$ 371,000	$ 636,000	$ 636,000	$ 636,000	$ 636,000	$ 2,915,000
Total Estimated Program Revenue		**$ 1,358,840**	**$ 4,463,520**	**$ 5,889,120**	**$ 5,889,120**	**$ 5,889,120**	**$ 23,489,720**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -	$ -	$ -	$ -
Revenue for Operations		**$ 1,358,840**	**$ 4,463,520**	**$ 5,889,120**	**$ 5,889,120**	**$ 5,889,120**	**$ 23,489,720**

	Program Expenses		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
1	**Salary**		$ 168,750	$ 739,786	$ 2,939,833	$ 3,855,245	$ 3,935,996	$ 3,935,996	$ 15,575,606
2	**Fringe**		$ 34,089	$ 186,997	$ 682,429	$ 903,102	$ 702,288	$ 702,288	$ 3,211,193
	Total Personnel Costs		$ 202,839	$ 926,783	$ 3,622,262	$ 4,758,347	$ 4,638,284	$ 4,638,284	$ 18,786,799
3	**Training & Professional Development**		$ -	$ 1,200	$ 1,200	$ 1,200	$ 1,200	$ 1,200	$ 6,000
4	**Travel**		$ 250	$ 161,350	$ 122,475	$ 167,444	$ 167,444	$ 167,444	$ 786,407
5	**Equipment**		$ 532	$ 7,965	$ 22,468	$ 22,101	$ 24,000	$ 24,000	$ 101,066
6	**Supplies**		$ 2,000	$ 1,190	$ 2,000	$ 2,500	$ 2,500	$ 2,500	$ 12,690
7	**Contract Services** (consulting, professional)		$ 1,000	$ 7,000	$ 24,000	$ 24,000	$ 24,000	$ 24,000	$ 104,000
8	**Software licensing**			$ 21,000	$ 72,000	$ 72,000	$ 72,000	$ 72,000	$ 309,000
9	**Telecommunications**		$ 1,244	$ 9,980	$ 39,139	$ 41,585	$ 43,000	$ 43,000	$ 177,948
10	**Occupancy** (rent, utilities, maintenance)		$ 13,278	$ 50,903	$ 93,550	$ 93,550	$ 93,550	$ 93,550	$ 438,380
11	**Other**		$ 2,190	$ 25,477	$ 21,036	$ 22,000	$ 22,000	$ 22,000	$ 114,703
	Total Direct Costs		$ 223,333	$ 1,212,848	$ 4,020,130	$ 5,204,727	$ 5,087,978	$ 5,087,978	$ 20,836,993
12	**Indirect Cost/Administrative Overhead**	10.0%	**$ 22,333**	**$ 121,285**	**$ 402,013**	**$ 520,473**	**$ 508,798**	**$ 508,798**	$ 2,083,699
	TOTAL EXPENSES		$ 245,666	$ 1,334,133	$ 4,422,143	$ 5,725,200	$ 5,596,776	$ 5,596,776	$ 22,920,693
	Surplus/Shortfall		*$ (245,666)*	*$ 24,707*	*$ 41,377*	*$ 163,920*	*$ 292,344*	*$ 292,344*	*$ 569,027*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Program Director	$ 75,000.00	1	4	$ 25,000
Clinical Care Manager (RN)	$ 67,500.00	1	4	$ 22,500
RN	$ 67,500.00	1	4	$ 22,500
Supervisor	$ 45,000.00	2	2	$ 15,000
Care Coordinators	$ 35,000.00	12	2	$ 70,000
Recovery Support Navigator	$ 35,000.00	1	2	$ 5,833
Certified Peer Coordinators	$ 35,000.00	1	2	$ 5,833
Medical Director	$ 250,000.00	0.05	2	$ 2,083
				$ -
Total Salary (Program Budget Line 1)		**19.05**		**$ 168,750.00**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 168,750.00	20%	$ 34,089
Total Fringe (Program Budget Line 2)			**$ 34,089**

Total Personnel*	**$ 202,839**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:The Program Director will oversee the CP sites, spending 100% of their time with program management, supervision and training staff. The Clinical Care Managers will spend 100% of their time reviewing and signing off on the comprehensive assessment of Enrollees and providing supervision of the Supervisors, the Clinical Care Manger (RN) will be a backup to the program RN and provide the same functions as the RN as required. The Registered Nurse in each site reviews any information on medications, treatment for chronic medical conditions and potential drug interactions and enter any additional findings into the field on Medical History and Medications for Enrollees. S/he will consult with a CCBC psychiatrist as needed.

Supervisors will oversee the activities of approximately 8 Care Coordinators. Supervisors may carry a small caseload and will assist in the hiring, supervision and support of the Care Coordinators.

Care Coordinators will work with the clients directly, complete Comprehensive Assessments and Person-Centered Treatment Plans, supporting the needs of the clients and completing all required case documentation.

Recovery Support Navigators will support Enrollees with their recovery from Substance Use or Co-Occurring Disorders by connecting them to recovery focused activities in the community and developing recovery oriented action plans.

Certified Peer Specialists will assist the Enrollee in developing an individualized WRAP plan to address the Enrollee's recovery needs and use their lived experience to support the Enrollee to move forward in their own recovery.

Medical Director will be available to the Team to aid as a clinical resource. During the Prep Period the Medical Director will be included in planning meetings to determine the flow of clients into the BHCP .

Row 3 - Training and Professional Development

	Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
52				
53				
54				
55				
56	**Total Training and Professional Development**			
57	**(Program Budget Line 3)**			

Provide a description of each Training and Professional Development line item included in the table above:

Row 4 - Travel

	Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
91	Program Director	50	4	0.5	$ 100.00
92	Clinical Care Manager	15	4	0.5	$ 30.00
93	RN	15	4	0.5	$ 30.00
94	Supervisor	25	2	0.5	$ 25.00
95	Care Coordinators	65	2	0.5	$ 65.00
96					$ -
97					$ -
98					$ -
99					$ -
100					$ -

	A	B	C	D	E	F	G
101				**Total Mileage**	$ 250.00		
102							

103	**Travel Expense Description**	**Cost**
104	Total Mileage	$ 250.00
105	Parking and tolls	
106	Public transportation	
107	Enrollee travel	
108	**Total Travel**	**$ 250.00**
109	**(Program Budget Line 4)**	

110

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

Mileage estimates includes travel to trainings and meetings to prepare for startup. Mileage is also estimated for recruitment events and interviewing candidates in various CCBC site offices.

129 **Row 5 - Equipment**

130	**Description of Equipment**	**Unit Cost or Cost/FTE**	**#units or FTEs**	**Cost**
131	Copier Rental	124		$ 248.00
132	Safety Device Monthly Monitoring	14.99	19	$ 284.81
133				$ -
134				
135				
136				
137				
138	**Total Equipment (Program Budget Line 5)**			**$ 532.81**

139

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

A copy machine will be rented for 2 months for a total cost of $248, based on actual cost of like machine.

CCBC utilizes a safety device that connects staff immediately to a live operator and allows for a GPS locator to the position of the device. The live operator can call for any type of police, fire or EMS response directly to the staff location. The live operator can also bring a supervisor online to speak to the staff member to help with the situation the staff member is facing. The cost is based on actual expenses that CCBC currently is contracted. There are 19 staff members that will need the monitoring of the devices set up and ready to use on June 1, 2018. The cost of the device is an initial price to purchase the device and then a monthly monitoring fee, somewhat like a monthly cell phone subscription. In the PBP there is not cost for the initial cost of the devices as they will be transferred from another department, therefore, no cost will be incurred to purchase the device. However, in

transferred from another department, therefore, no cost will be incurred to purchase the device. However, in the PBP there will be a monthly cost incurred to monitor the device, equal to one month of service. We do not want to wait until June 1, 2018 to start the monitoring service as we want all devices programed and tested prior to June 1, 2018. Each staff member creates a profile of information that is able to be accessed when the device is activated, this is how a staff member can get immediate response from their supervisory support network at CCBC. CCBC currently use this device in all of our outreach programs and believe it is an important piece of the safety protocol for our staff members.

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Office Supplies			$ 2,000.00
Total Supplies (Program Budget Line 6)			**$ 2,000.00**

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

CCBC will supply the CP sites with office supplies for organization of staff, training, clients information. CCBC expects CP staff to be located in at least two separate office locations. The projected expense is $2,000 supplies will be shared between sites.

The cost projected is consistent will like programs that CCBC is currently running. The types of supplies purchased as associated costs are listed below. CCBC expect to have 23 staff in the PBP and will expand to more than 30 staff in year 1 and over 70 staff in year 2. While CCBC projects the cost in the PBP of $2000 for 4 months of readiness, it expects the costs to stabilize as the program goes into year 1 and 2 even though the number of staff is expanding. Costs are associated with office start up and include the following costs at the current prices. Office supplies will be an ongoing expenses for all years of the BHCP.

Pens $1/dozen, 15 = $15
Color Copies 10 cents each 1000 = $100
Toner $70/unit, 4 = $280
Paper $30 per case, 6 = $180
Note Pads $6/dozen, 4 = $24
Folders $5/100, 4 = $20
Post It $17 per pack, 6 = $102
2" Binders $12/each, 20 = $240
Tabs for Binders $3/each, 20 = $60
Desk set, stapler, tape dispenser, staple remover $17/set, 5 =$ 85
White Boards $35, 4 = $140
Envelopes $14/box, 4 = $56
Protector sheets $9/box, 2 = $18
Binder Clips, sum, med, large $10/3 boxes, 8 = $80

Folders for clients box 25 $15, 40 = $600

Total $2000

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Sensible Computer	IT Support		$ 1,000.00
Total Contract Services (Program Budget Line 7)			**$ 1,000.00**

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Sensible Computer provides hardware and software integration as well as computer training on a contracted basis. Sensible Computer will support the CP performance by preparing the staff to utilize the technology to completed patient records. The cost was determined by past experience and an estimate of number of hours required to complete tasks.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
No software licensing in the Prep Period			
		Total Software Licensing	

	A	B	C	D	E	F	G
252			**(Program Budget Line 8)**				

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

	Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
287	Land Lines and Fax Line	$900	1	$ 900.00
288	Cell Phone Lines	16	12	$ 192.00
289	Cell Phone Lines 1/2 month	8	19	$ 152.00
290				
291				
292			**Total Telecommunications**	
293			**(Program Budget Line 9)**	**$ 1,244.00**

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Using the cost for a similar site office the estimate for the necessary fax and phone lines is projected at $900 per site per month in the prep budget. There will be one month of cost for two sites. These lines will allow for the communication necessary to set up the program.

The cost of the cell phone on a monthly basis in CCBC current phone plan is $16. Three staff members will have cell phones for 4 months and 19 staff members will have cell phones for 1/2 month during the Prep period. This communication will allow for staff to be ready to outreach clients at the start of year 1.

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent	2200	14.5	$ 6,645.83
Rent	1500	17.5	$ 5,468.75
Utilities			$ 695.00
Cleaning			$ 468.00
Total Occupancy (Program Budget Line 10)			**$ 13,277.58**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

The cost in the Occupancy line will allow the staff to have a cohesive work unit in which to attend meetings, supervision and begin preparation to work with clients. In the PBP the number of staff in each site will be eight staff. At the end of year 1 there will be approximately 20 staff members in each site.

The Rent for the 1st sites is projected to be $2,658.33 per month, the Rent for the second site is projected to be $2,187.50 per month. It is expected that the property will be rented for 2.5 months of the prep period.

Cleaning and utilities are an expense attributable to the CP site office and is based on current payments to cleaning companies.

Row 11 - Other

Other Direct Expense Description	Cost
Advertising Brochure Design and Printing	$ 875.00
Business Cards for Staff	$ 925.00
Shredding Services	$ 130.00
Internet Connections	$ 200.00
Security System for Site	$ 20.00
Answering Service for Program	$ 40.00
Total Other (Program Budget Line 11)	**$ 2,190.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Advertising Brochure Design and Printing - CCBC will design and print a brochure to use with physicians and potential clients to highlight the BHCP service. This brochure will aid in the promotion and understanding of the process to help engage PCPs and office staff on the process and how to work with a BHCP. Expenses are based on recent production of similar service brochures.

Business Cards - CCBC will print individual business cards for each staff member working on the BHCP Team. This is essential as it provides direct contract information that will be shared with PCPs offices to assist in the enrollment process. The cost is consistent with current expenses.

Shredding Services, Internet Connections, Security and Answering Service - All of these expenses are necessary for the operation of a BHCP site. These expenses will allow for an efficient and safe BHCP site. These expenses are direct to each site and consistent with current expenses.

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	**10.00%**	**$ 22,333.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

The leadership team at CCBC is committed to the successful launch of the BHCP. This expense will cover the cost of the CEO, CFO, COO and department VPs to plan and activate the activities of the launch of the BHCP over the preparation period. The expense will also cover the necessary liability insurance coverage necessary, additional patient billing supports. A portion of costs associated with normal business function such as auditing, payroll, legal, telephone, postage, association memberships will be attributed to the BHCP based on acceptable accounting practices. These costs are based on current projections of expenses.

Community Partner Infrastructure Budget Report

Community Counseling of Bristol County, Inc.

Infrastructure Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
PMPM Infrastructure Rate		$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
Engaged Enrollees		942	942	2,432	2,432	2,432	
Estimated Infrastructure Funds		$ 659,400	$ 972,709	$ 1,502,684	$ 1,324,954	$ 1,146,348	**$ 5,606,094**
At- Risk Withhold Rate			25%	44%	63%	81%	
Withhold			$ 243,177	$ 661,181	$ 834,721	$ 928,541	**$ 2,667,621**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 659,400	$ 729,532	$ 841,503	$ 490,233	$ 217,806	**$ 3,388,474**

	Infrastructure Investment Projects		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
	Technology								
1	**IT Staffing including Fringe**		$ 4,167	$ 17,500	$ 31,200	$ 32,400	$ 32,400	$ 33,600	**$ 151,267**
2	**Development Adaptation of EHR and/or Care Management System**		$ 125,000	$ 30,000	$ 15,000	$ 10,000	$ 10,000	$ 10,000	**$ 200,000**
3	**Technology for Service Delivery**		$ 13,800	$ 10,800	$ 18,600	$ -	$ -	$ -	**$ 43,200**
4	**Other Technology Expenses**		$ -	$ 12,000	$ 12,000	$ 700	$ 7,000	$ 7,000	**$ 38,700**
	Total Technology		$ 142,967	$ 70,300	$ 76,800	$ 43,100	$ 49,400	$ 50,600	**$ 433,167**
	Workforce Development								
5	**Workforce Development staffing including Fringe**		$ -	$ 7,750	$ 7,750	$ 7,750	$ 7,750	$ 7,750	**$ 38,750**
6	**Recruitment Expenses**		$ 18,000	$ 20,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	**$ 78,000**
7	**Training Expenses**		$ 3,900	$ 20,200	$ 15,000	$ 15,000	$ 15,000	$ 15,000	**$ 84,100**
8	**Retention Expenses**		$ -	$ 25,000	$ 25,000	$ 25,000	$ 25,000	$ 25,000	**$ 125,000**
	Total Workforce Development		$ 21,900	$ 72,950	$ 57,750	$ 57,750	$ 57,750	$ 57,750	**$ 325,850**
	Business Start Up Costs								
9	**Office Equipment (PBP & BP1 only)**			$ 10,000.00					**$ 10,000**
10	**Office Furniture (PBP & BP1 only)**		$ -	$ 20,000.00					**$ 20,000**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**		$ 245,666	$ -	$ -	$ -			**$ 245,666**
	Total Business Start Up Costs		$ 245,666	$ 30,000	$ -	$ -			**$ 275,666**
	Operational Infrastructure								
12	**Operation Staffing including Fringe**		$ -	$ 40,000	$ 40,000	$ 40,000	$ 40,000	$ 40,000	**$ 200,000**
13	**Other Operational Expenses**		$ 20,891	$ 24,000	$ 9,000	$ 9,000	$ 9,000	$ 9,000	**$ 80,891**
	Total Operational Infrastructure		$ 20,891	$ 64,000	$ 49,000	$ 49,000	$ 49,000	$ 49,000	**$ 280,891**
14	**Indirect Cost/Administrative Overhead Rate**	10.0%	$ 18,576	$ 23,725	$ 18,355	$ 14,985	$ 15,615	$ 15,735	**$ 106,991**
	TOTAL INVESTMENTS		**$ 450,000**	**$ 260,975**	**$ 201,905**	**$ 164,835**	**$ 171,765**	**$ 173,085**	**$ 1,422,564**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Data Analysis/Quality Manager	$ 50,000.00	0.5	2	$ 4,167
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary			$ 4,167
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 4,167**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Data Analysis/Quality Manager oversees the data collection and integrity, designs necessary reports, supports quality initiatives and designs quality improvement projects to improve outcomes.

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Care Management Program	$ 125,000.00

	A	B
34		
35		
36		
37		
38		
39	**Total Development and Adaptation of EHR and Care**	
40	**Management System**	$ 125,000.00
41	**(Infrastructure Budget Line 2)**	
42		
43	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***	
44	***contract and how the costs were determined:***	
45		
46	***CCBC has been working with a vendor to design a care management program that will meet the needs of the BHCP program. The***	
47	***software vendor has been designing the system to meet the reporting requirements and tracking needs of the BHCP Program.***	
48	***The Care Management Software is critical to meeting the requirements of the BHCP program. An updated projected costs was***	
49	***provided on 10/5/17, CCBC is allocating $125,000 towards the total projected costs of $175,000 in the preparation period.***	
50		
51		
52		
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54		
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56		
57		
58	**Row 3 - Technology for Service Delivery**	
59	**Description of Expense**	**Cost**
60	Laptops	$ 13,800.00
61		
62		
63		
64		
65		
66	**Total Technology for Service Delivery**	$ 13,800.00

	A	B	C	D	E	F	G
67	**(Infrastructure Budget Line 3)**	$ 13,800.00					
68							
69	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
70	***contract and how the costs were determined:***						
71							
72	***CCBC will purchase Laptops with air cards to be utilized by all BHCP staff. Twenty-three laptops will be purchased in the PBP,***						
73	***23 FTEs will receive the laptops, the laptops will be configured to specifications and use on June 1, 2018. The current unit price***						
74	***for a laptop is currently $600 which includes a case for the equipment. Prices were determined by reviewing the pricing with***						
75	***our hardware vendor utilizing the HP Business Connect Program.***						
76							
77							
78							
79							
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82							
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84							
85	**Row 4 - Other Technology Expenses**						
86	**Description of Expense**	**Cost**					
87							
88							
89							
90							
91							
92							
93	**Total Other Technology Expenses**	$ -					
94	**(Infrastructure Budget Line 4)**						
95							
96	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
97	***contract and how the costs were determined:***						
98							
99							

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
			4	$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate	24.0%	Total Fringe	$ -
			Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

The Program Trainer will work exclusively with the BHCP Team to formalize training plans and then train the staff that will be joining the team. This training will ensure that all staff are prepared to fulfill the duties of their positions.

Row 6 - Recruitment Expenses

Description of Expense	Cost
Indeed Direct Hires	$ 3,000.00
Indeed Sponsored Ads	$ 5,000.00
Bayard Advertising	$ 10,000.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 18,000.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

CCBC will use multiple avenues for staff recruitment, it is imperative that CCBC recruit motivated engaged staff for the successful implementation of the BHCP. CCBC will utilized Indeed' s Direct Hire product that performs the aspects of a job placement service with a much lower cost per hire than a traditional recruiting firm. CCBC will also sponsor ads on the Indeed website which allow for our advertising to stay at the top of the searches for an extended period of time highlighting the jobs BHCP CCBC has open. CCBC will also use the services of Bayard, Bayard optimizes the internet exposure of the BHCP jobs available at CCBC. These costs are all estimates based off the actual costs of the most recent large hiring project CCBC just completed.

Projection of Bayard Costs
Landing Page Creation $2,900
Facebook Postings $800/ month for 2 months = $1600
Landing Page Hosting $750 / month for 2 months = $1500
Application Feeder $1000 / month for 4 months = $4000

Row 7 - Training Expenses

Description of Expense	Cost
Community Health Worker Training	$ 3,900.00
Total Training Expenses (Infrastructure Budget Line 7)	**$ 3,900.00**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

CCBC will send staff to a Community Health Worker Training to aid in the training of the direct care staff and is based on the known cost of the training. The cost per person of the training is $650, CCBC will make serval payments of $650 training a total of six staff during the PBP.

Row 8 - Retention Expenses

Description of Expense	Cost

	A	B	C	D	E	F	G
199							
200							
201							
202							
203							
204	**Total Retention Expenses**	**$ -**					
205	**(Infrastructure Budget Line 8)**						
206							
207	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms***						
208	***of the CP's contract and how the costs were determined:***						
209							
210							
211							
212							
213							
214							
215							
216							
217							
218							
219							
220							
221							
222							
223	**Community Partner <u>Infrastructure</u> Budget Report - Business Start Up Costs - Prep Budget Period**						
224							
225	**Row 9 - Office Equipment**						
226	Description of Expense	Cost					
227							
228							
229							
230							

	A	B	C	D	E	F	G
231							
232							
233	**Total Office Equipment**	**$ -**					
234	**(Infrastructure Budget Line 9)**						
235							
236	***Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were***						
237	***determined:***						
238							
239							
240							
241							
242							
243							
244							
245							
246							
247							
248							
249							
250							
251							
252	**Row 10 - Office Furniture**						
253	Description of Expense	Cost					
254							
255							
256							
257							
258							
259							
260	**Total Office Furniture**						
261	**(Infrastructure Budget Line 10)**						
262							
263	***Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were***						

determined:

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe (Infrastructure Budget Line 12)	**$** -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 13 - Other Operational Expenses

Description of Expense	Cost
Data Analytics	$ 5,000.00
Project Management	$ 15,891.00
Total Other Operational Expenses (Infrastructure Budget Line 13)	**$ 20,891.00**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

CCBC plans to utilize consultants to handle Data Analytics and Project Management. These consultants will work with CCBC to manage and implement the necessary steps to set up and be ready to accept assigned enrollees on June 1, 2018. These consultants will work in concert with CCBC leadership. The consultants will help drive the phases of implementation forward from ACO Contracting to software integration, and reporting capabilities. CCBC plans to use Systematics to assist CCBC with Data Analytics, reporting capabilities and electronic interfaces. These costs are estimates based on like projects that CCBC has recently implemented. All costs are solely related to the process of establishing the systems necessary to the BHCP project. No funds will be spent on non-BHCP activities.

It is expected that the cost per hour of the Project Management portion will be $160 per hours for approx 99 hours. It is expected that the cost per hour of the Data Analytics will be at $100 per hour for approx 50 hours.

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	10.00%	$ 18,576.00

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

CCBC applied its most recent overhead rate equally to the Program Budget and the Infrastructure budget. This percentage is a total of 10% of all costs of the contract and will cover the following. This expense will cover the cost of the CEO, CFO, COO and department VPs to plan and activate the activities of the launch of the BHCP over the preparation period. The expense will also cover the necessary liability insurance coverage necessary, additional patient billing supports. A portion of costs associated with normal business function such as auditing, payroll, legal, telephone, postage, association memberships will be attributed to the BHCP based on acceptable accounting practices. These costs are based on current projections of expenses.

	A	B	C	D	E	F	G
358							
359							
360							
361							
362							

Community Partner Infrastructure Allocation Worksheet

	N/A Community Counseling of Bristol County, Inc.						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 659,400	$ 729,532	$ 841,503	$ 490,233	$ 217,806	$ 3,388,474
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL INVESTMENTS	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Development and Adaptation of	Establish software that can send and receive information	10/01/17	06/01/18	Software is deisgned and in testing phase at	CCBC BH CP staff are able to test			Software has been successfully installed.	BH CP staff can send and receive member		
Technology												
Technology												
Technology												
Workforce Development	Recruitment Expenses	Establish a competent workforce for BH CP	11/01/17	05/31/18	Candidates interviewed and hired	List of qualified candidates			Full complement of staff for start	Staffing roster is completed		
Workforce Development	Program Staffing including Fringe	Planning for successful implementation	02/01/18	05/31/18	Key staff on board	Full time program director and			Full team of BH CP hired	Staffing roster is completed		
Workforce Development												
Workforce Development												
Business Start Up Costs	Office Equipment	Ensure staff have resources to achieve goals of BH CP	02/01/18	05/31/18	Purchase and installation of phones and	All staff hired during prep period			Purchase and installation of phones and	The full complement of BH CP staff have		
Business Start Up Costs												
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Ramp-up Costs	Provide office space and logistical support to BH CP Staff	02/01/18	05/31/18	Integrate BH CP program into CCBC programs	Identified relationships within CCBC			Established policies and procedures for BH CP	Program staff are ready to operate BH CP		
Operational Infrastructure												
Operational Infrastructure												
Operational Infrastructure												

BH Community Partner - Staffing Model

Insert Contractor Name Here

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	942	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	1	*Total management oversight of BH CP*
3	Medical Director		*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs	4	
5	Clinical Care Managers		*Do not include FTEs listed in line 4*
6	Clinical Care Managers (LPHA)	1	*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders	5	*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff		*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	33	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)	2	*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists		
12	Administrative Support		
13			
14	Total FTE	46	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1 : 235	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	1 : 8	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff: The Supervisor Team Leader will directly supervise the Care Coordinators.

7.3 Initial DSRIP Plan

A. Executive Summary

Describe five year business plan for implementing the CP program

Community Counseling of Bristol County (CCBC) is pleased to submit this Request for Response to MassHealth to become a Behavioral Health Community Partner (BH CP). CCBC is applying as an individual provider and seeks to serve Enrollees in the areas of Attleboro, Brockton and Taunton in the Southeast Region. Our projected volume will be 2,432 enrollees.

CCBC is well positioned to serve MassHealth members in these areas who present with Serious Mental Illness, Substance Use Disorders, have complex co-occurring medical conditions, and have been affected by or at risk of losing access to health care due to a host of social determinants.

Our agency has a long history of providing service to these communities since 1970: We are the largest provider of outpatient behavioral health services in these communities. We serve the most DMH clients in our PACT and CBFS programs in Attleboro, Brockton and Taunton. CCBC is the Community Service Agency (CSA) serving children with Severe Emotional Disturbances and their families in the Taunton/Attleboro area. Our Community Support Program (CSP) works with primary care providers, hospital Emergency Departments and Inpatient psychiatric units in these areas and across the Southeast. CCBC is able to engage 75% of the referrals we receive, a key competency for the Behavioral Health Community Partners.

These services are complemented by a wide range of other social services provided by CCBC, including Emergency Services, partial hospital and day treatment, HIV Services, specialty housing, Elder Mobile Outreach, and an active community presence on initiatives related to health and wellness, prevention of opioid overdoses, and suicide prevention.

The agency's capacity to perform as a BH CP is also enhanced by our close working relationship with Steward Health Care in five ICB contracts that include care coordination activities that resemble much of what is required in this RFR.

Our five-year business plan under this model will start upon notification of award. During our preparation period, we will design and install the care management module and recruit key staff, including enough Care Coordinators to begin activities with 640 referrals on June 1, 2018.

We view program years one and two as a time to implement the program fully, establish working relationships with the ACOs in these areas, primarily Steward, BMC BACO, BMC-Signature, and the Community Care Collaborative, while developing an alignment with these stakeholders and community providers to understand the population identified by MassHealth.

Year three will be a year to implement targeted population health interventions based on the strengthened alignment that includes population health analysis to address gaps in care among all of the stakeholders. In years four and five CCBC envisions consolidation of the program model and a transition to shared savings and shared risk with the ACOs and MCOs as the value of the BH CP is identified.

Within this plan, we recognize the many challenges, including engaging persons who have not yet reached the stage of change where they will accept help, or who only intermittently touch behavioral health services. We have built the culture of the agency to be responsive to referral sources, individual clients, and other providers to be of service when requested. CCBC will be ready to stand up as the BH CP on day 1 with a skilled, trained, and competent workforce backed by an agency with a strong reputation in these communities.

Another challenge is the perception of behavioral health as a second-class health care diagnosis, along with the providers who deliver the services. CCBC has been addressing this obstacle through our strengthening partnership with Steward Health Care, our collaboration with Brockton Neighborhood Health Center as a supporter of our program in Brockton, and our continuing relationship with Greater New Bedford Community Health Center.

The longer-term challenge for this program is to align the stakeholders (MassHealth, MCOs, MBHP, ACOs, and providers) towards a common understanding of the population in terms of gaps in care and outcomes that can be achieved; a common perspective on how to drive care towards efficiencies in service delivery and improved management of the care; and alignment of payment methodologies to reward stakeholders less for volume and more for outcomes. This is a long-term goal. If common methods of profiling the population's patterns of care, service utilization, and formula for Total Cost of Care are developed by Year 3, we will be prepared for assuming some type of risk with the ACO partners in graduated levels in years 4, 5 and beyond.

CCBC will address the workforce shortage in behavioral health care by drawing from our staff of CSP workers to become Care Coordinators. We expect to add between 300 and 450 more Enrollees each quarter to reach our full capacity at the end of year 2. Our DSRIP funding will allow for hiring, training and orienting these staff over the course of four months prior to implementation, allow for sufficient investment in our Care Management module, and related operational costs.

We recognize the challenges of recruiting up to 74 Care Coordinators that a fully implemented program will entail as well as the technological challenges of starting up a new Electronic Care Management module that can improve communication with the ACOs. However, we are gaining invaluable experience in our current project with Steward Health ACO Pilot, our CSP program, and our growing community presence in prevention, education, housing support and outreach activities in these communities.

These are some of the challenges and opportunities of "Incremental Care" as described by Atwul Gawande that will become more of a focus of health care delivery, especially for Medicaid populations and especially for persons who are affected by social determinants of health and also have the complex, co-occurring conditions described by MassHealth in this RFR. CCBC is well positioned to address these challenges and build strong partnerships with ACOs, MCOs and other providers to chart a path to improved outcomes and reduced total cost of care.

B. Supporting Populations and Community Engagement

1. For each Service Area describe connections to the community, including current/planned collaborations/partnerships with community-based organizations, advocacy groups, BH service providers, housing/shelter providers, and social service organizations in order to support the focus population.

Taunton and Attleboro: CCBC has been delivering community-based mental health and substance use disorder services in the Taunton-Attleboro Service Areas for over 45 years. CCBC's service array has expanded to address the homeless population, veterans, persons with HIV, the elderly, and prevention and education programs over the past 20 years. Our connections to these communities are broad and deep and will continue to grow as a BH CP. Below is a list of the key collaborations that will be integrated with the BH CP care coordination activities:

- Greater Bristol County/Attleboro/Taunton Coalition to End Homelessness. In addition to providing a number of housing programs for Veteran's, homeless and those with substance use disorders, CCBC serves as lead agency for the region's HUD grant that brings close to $1 million to the area each year. EEs will have access to these resources to secure stable housing. The Taunton and Attleboro Housing Authorities are active members providing valuable resources available to EEs.
- Taunton Mayor's Office. CCBC participates in the Mayor's Opiate and Substance Use Task Force focusing on the reduction of opioid overdoses and participates in a host of community education and prevention programs that will be a resource for the BH CP population with substance use disorders or at risk of disorders.
- The regional Prevention and Wellness Task Force (CHNA 24) convened by DPH that covers area wide health, prevention and community public health programs. CCBC staff has been active with this group for 25 years.
- Attleboro YMCA and the Old Colony YMCA. CCBC works with the Attleboro and Taunton YMCA's as the site of health education, wellness activities and group exercises for clients in the CBFS and PACT programs incorporating the In-Shape Evidence-based practice.
- Community Crisis Intervention Team. Over the past 10 years in partnership with the Taunton Police Department, CCBC has trained 600 police officers, with a major focus on Attleboro and Taunton police, probation officers and other human service professionals in understanding serious mental illness and effective crisis intervention methods. Program goals include fostering safe/productive encounters between those with SMI and law enforcement and diverting those with SMI from the criminal justice system when appropriate.
- Elder Mobile Outreach Team (EMOT). With support from Bristol Elder Services, the local Aging Services Access Point, for the past 10 years CCBC has operated EMOT, which offers a collaborative case model of mobile treatment services through eight local Council's on Aging and the regional ASAP.
- Suicide Prevention Services. CCBC is an active member of the Bristol County Regional Coalition for Suicide Prevention and coordinates the DPH grant for Southeastern MA.
- Safe Neighborhood Initiative (SNI). CCBC is a member of the SNI which is comprised of public safety, probation, community development, and human services personnel addressing a broad range of public safety concerns for the City of Taunton.
- MassHealth, Taunton and Brockton office. CCBC is a Designated Certified Application Counselor Organization in Taunton, Attleboro, and Brockton on behalf of the Health Connector.

- National Alliance Mental Illness. CCBC has a longstanding relationship with NAMI as a training resource and local partner.
- Transformation Center. CCBC has utilized the consultation services of the Transformation Center with respect to its development of the role of peer specialists in service delivery.

Brockton:

- Brockton Neighborhood Health Center. this CHC, which is one the founding members of the Community Care Collaborative, will be a partner with CCBC for the BH CP clients receiving primary care services at their CHC.
- Cape Verdean Social Club. The CCBC CSP program has worked with this organization when members are referred to help with access to health care services. The BH CP will continue that relationship and engage the members of the social club as natural community supports for EEs who identify the CVSC as a resource.
- Haitian Social Club. The CCBC CSP program has worked with this organization when members are referred to help with access to health care services. The BH CP will continue that relationship and engage the members of the social club as natural community supports.
- Good Samaritan Hospital. The Hospital first approached CCBC six years ago to assist with over utilization of the ED through its Community Support Program.
- Mainspring Homeless Shelter. The BH CP will initiate monthly meetings on EEs who are homeless and living at the shelter as a renewal to similar case review meetings conducted by the CCBC CSP programs in 2010-2015.
- Brockton Police. CCBC will provide Crisis Intervention Training (CIT) to the police to help intervene in psychiatric emergencies under the auspices of the ESP.

2. Describe how CCBC will grow its connections to the community in Service Areas.

CCBC's currently operating CSP and PACT programs provide a strong presence in Brockton, and a solid reputation and foundation of expertise that will allow the BH CP to build customized models of care coordination, health and wellness activities, seamless transitions of care from hospital ED's, and inpatient med-surgical units. The connections will also grow as CCBC implements the ESP program in Brockton, replacing the state-operated program.

To promote a strength-based, recovery-oriented approach to serving Engaged Enrollees CCBC's BH CP will recruit Certified Peer Specialists who have been trained by the Transformation Center as well as Recovery Coaches as potential BH CP staff. The BH CP will also develop collaborations with the RLC's and the RSC's to train members of the ACO and BH CP Care Teams on recovery principles and to encourages EE's to utilize the supports of these services.

3. Describe its plans to ensure staff is informed of community resources over the course of the Contract Term.

CCBC's has already established a number of programs and community partnerships in Taunton, Attleboro and across Bristol County to ensure that all staff, including newly hired BH CP staff, are aware of community resources in the Taunton and Attleboro areas. In Brockton, the ESP will have nearly 12 months of experience by the time of the start of the BH CP program in providing much needed interventions to vulnerable populations many of whom will be identified as potential Enrollees for the BH CP. Combined with the CSP, CCBC will have a host of community resources that are updated through the work of CSP and ESP programs to ensure their effectiveness.

C. Community Partner Supports and Activities

1. Outreach and Active Engagement

Outreach: CCBC understands the challenges of outreach and engagement of persons with severe and persistent mental illnesses and persons with substance use disorders in community settings. We have a proven track record with this population, linking 2,500 members annually through our Community Support Program (CSP) to needed services for primary care, outpatient and diversionary behavioral health services along with community based supports for housing, shelter, basic needs, training and employment. CCBC will adopt the best practices of the Community Support Program by using multiple methods of contacting the client, including at their home, in the hospital emergency department, and through the ACO's provider network by using phone, email and texting as preferred by the Assigned Enrollee.

At the time of initial engagement, the CP staff will provide necessary information about the Community Partner program, the benefits, supports, and advocacy for the Assigned Enrollee should s/he decide to participate. The CP will also inform the Assigned Enrollee that they may opt out of the program at any time. As part of the initial conversation, the CP will also explain the Enrollee's right to privacy around disclosures of Protected Information and help the Enrollee choose which disclosures to allow.

Engagement: Assessing what concerns the Enrollee may have is critical in the initial period of engagement. Care Coordinators need to be empathic active listeners in order to help the Enrollee feel comfortable to share their personal needs. Although the BH CP program will focus on the care coordination of a host of healthcare and social services, the Enrollee may also be dealing with other areas that are causing stress that may be a barrier to engagement in services.

However, also at this stage, CP's role is one of collaboration with referring agency, providers, and the client to assure access to coordinated services including diagnostic, pharmacological, emergency, recovery, and other treatment and community services. Successful early engagement is vital to reversing the path towards a destructive loss of functioning, increased incidence of substance use or relapses, return to homelessness, or involvement with criminal justice.

a – b Planned Strategies of Outreach and Engagement.

One successful strategy is to respond to a client request or a request from a referral source such as a PCP or ED personnel as quickly as possible. CCBC practices this strategy engagement by its established practices of Centralized Intake and Open Access models which are practiced in Community Support Program (CSP), Community Service Agency, and Outpatient treatment programs with great success. CCBC will incorporate those models into the BH CP program. In addition to timely appointments with the Enrollee, the CP worker will deploy another strategy: *to be assertive with the client by using statements such as "When we meet, what do you want to discuss about your needs and goals?" Or, "At your meeting next week, we will discuss how the program works and ask you about your dreams, preferences and cultural affiliations."* This approach contributes to the 75% engagement rate in the CSP program in the past five years.

A second successful strategy of engagement in the first meetings with the Enrollee is to establish their needs, wants, and dreams that are based on their strengths and preferences. This approach is an evidence base in the Wraparound Model of Care. Other areas of exploration of the enrollee's

strengths include natural community supports in their social circles, such as close relatives and local clergy.

A third strategy maintains the Enrollee's involvement in providing small *"wins"* for the Enrollee that is easily achievable at the outset, especially for those who are homeless. *"Small wins"* include helping the Enrollee obtain food stamps and transportation vouchers. These successes act as a bridge to larger goals, such as permanent housing, linkage to their assigned PCP, and appointments for behavioral health treatment.

From operating a CSP that is successful in engaging members who are referred from other providers, several procedures have produced very positive results in outreach and engagement across the agency:

- Using text messaging to hospital ED staff provides direct and timely information and allows the hospital employee to respond when time becomes available;
- Planned strategies for outreaching to and engaging with Assigned Enrollees with Substance Use Disorders, such as assigning Recovery Coaches to support the client at the initial stage of engagement; and applying the principles of *"Seeking Safety,"* a trauma-informed treatment approach that focuses on the development of safe coping behaviors for veterans and others who have substance use disorders and have experienced trauma.
- CCBC is the only provider in the Southeast region who has been trained in the evidence based practice of Illness, Management and Recovery (IMR) in the work with the Community-Based Flexible Supports (CBFS) program. CCBC has experience in outreaching and engaging Assigned Enrollees through their contracts with DPH-BSAS for Section 35 and BSAS Supported Case Management programs. BH CP staff will be trained in the Motivational Interviewing (MI) evidence-based practice for engaging persons with substance use disorders as described in the SAMHSA Treatment Improvement Protocols (TIP) #42. The key strategies of MI to be incorporated are: Express Empathy, Develop Discrepancy, Roll with Resistance, and Support Self-Efficacy (from SAMHSA TIP #42, p.114). In other words, work in partnership with Assigned Enrollees to begin to develop their path to recovery on their own terms at a pace they are comfortable with, using the support of staff to explore their potential to make lasting change.
- Three CCBC staff have recently been ordained as Motivational Interviewers and are certified to train other staff in this evidence-based practice that is especially effective for persons with SMI, substance use disorders and co-occurring substance use and mental health disorders.

c. Planned process to obtain/document AE's agreement to participate in CP Supports through a participation form:

The BH CP program will emulate the CCBC CSP program's successful model of engagement of members:

- Outreach via telephone the Enrollee and Enrollee-identified supports;
- Timely response to a request from referral sources or primary contacts for the Assigned Enrollees via a centralized phone intake;
- Timely follow through to a face-to-face within 30 minutes of request during business hours;
- Explaining the BH CP program to the client in context with their identified needs, hopes, dreams and goals and explaining the process of developing a plan to reach the goals that includes signing a participation form and releases of information to get information from

other providers and to involve them in the planning – all with the Assigned Enrollee's written consent.

- Assigning a Care Manager at the completion of the first meeting and establishing an appointment for the next meeting to review goals established;
- Obtaining written consents and other points of contact – family, relatives, friends and natural community supports that provide an alternative means of contacting the client;
- Including the signed permission and initial information in the AE's record.

2. Comprehensive Assessment and Person-Centered Treatment Planning
Include attachment A (section 2.3.B) of Assessment Tool(s)
Describe plans to satisfy Comprehensive Assessment and Person-Centered Treatment Planning requirements using evidence-based or emerging practices.

CCBC understands that a complete and thorough Comprehensive Assessment is the foundation to effective intervention with the Enrollee in the BH CP program. CCBC's experience with this population in the CBFS, PACT, Outpatient and CSP programs has validated this approach in developing feasible and effective client-centered, strength-based and recovery-oriented interventions.

a. Process for conducting the Comprehensive Assessment (CA):

The assigned Care Coordinator schedules a face-to-face meeting with the Assigned Enrollee to: identify Assigned Enrollee's needs, describe process, confirm their willingness to participate, explain the rationale for signatures to participate, explain the rationale for need to gather information from other providers and obtain signed consents for release of information. During this process, the Care Coordinator will explain the steps to completing the CA and will offer help with the Assigned Enrollee's immediate needs as steps to completing CA. Before setting up the next meeting to continue the assessment if needed, the CP staff person will "check in" with the Assigned Enrollee to see if this process has met his/her needs and ask or any suggestions to make it better. This "check-in" is an emerging best practice in the CCBC Program for Assertive Community Treatment (PACT) and CBFS programs.

At each subsequent meeting, the Care Coordinator will explore goals, level of functioning, family, natural supports and review information that has been obtained from other sources such as PCP's and behavioral health providers. Once all information has been obtained and reviewed by the Care Coordinator and registered nurse as needed, the completed assessment will be reviewed with the Enrollee. At the end of each meeting the Care Coordinator will again complete the "check in" process described above. During these meetings, the staff person will deploy the Guiding Principles of Motivational Interviewing to support continued engagement of the member: Express Empathy, Develop Discrepancy, Roll with Resistance, and Support Self-Efficacy.

The BH CP staff will all participate in the gathering of information by following up with other providers, scheduling appointments and consulting with registered nurses on the medical information. CCBC believes that engagement with the Assigned Enrollee will be most effective when the Enrollee works with one consistent Care Coordinator during this process. This practice addresses a common frustration from members that they have to repeat their story to many different parties in order to get service.

CCBC's Electronic Health Record for this program will contain fields for 21 domains contained in Attachment A. As needed, the BH CP nurse will review any information on medications, treatment for chronic medical conditions and potential drug interactions and enter any additional findings into the field on Medical History and Medications. S/he will consult with a CCBC psychiatrist as needed. In the final step, the Clinical Care Manager will review this assessment and sign off on its completion within three calendar months of the Assigned Enrollee's assignment to the BH CP program and make the assessment available to members of the Assigned Enrollee's Care Team, ACO and MCO, state agency representatives and other case managers as consented to by the Assigned Enrollee.

a. The process for conducting Person-Centered Treatment Plans shall include:

1) Planned processes for developing the Person-Centered Treatment Plan.

CCBC's approach to developing the Person-Centered Treatment Plan will be built upon the Best Practices the agency uses in their PACT program for Adults and the Wraparound Model of Care for Children in their Community Services Agency (CSA). The plan will be developed during the course of the meetings between the Enrollee and the Care Coordinator. S/he will begin with the Assigned Enrollee's original reason for referral and become more informed by their answers to questions about the Assigned Enrollee's dreams, needs, strengths, and preferences that will help to clarify their personal goals. The Assigned Enrollee's care goals will emerge from the sum of information gathered from the assessment of their treatment history, level of functioning, medical history, and history of mental health and substance use disorder treatment, including medications. The Care Coordinator will frame the plan within a recovery-oriented, strength-based approach to the Assigned Enrollee, his/her family and other supports they identify and include acknowledgement of the barriers that contributed to housing instability , food insecurity, and social isolation and how they affect health outcomes. The Recovery Support Navigator and/or Certified Peer Specialist will assist the Assigned Enrollee in developing an individualized plan to address their recovery needs. The CC will ask the Assigned Enrollee for permission to get input into the Care Plan from other involved parties such as the PCP, Specialty Healthcare provider, and representatives from other behavioral health, social service and community organizations and case managers whom the Assigned Enrollee has identified.

Once the plan is completed, the CC will review the content with the Clinical Care Manager for approval and send to the PCP and/or ACO representative for his/her sign-off before assembling the full team to review and plan for next steps.

CCBC has staff that are trained facilitators in the Person-Centered Planning, a DMH-approved model for development of a care plan that will be deployed in the BH CP.

2) Planned processes for documenting the Person-Centered Treatment Plan.

CCBC will establish a Person-Centered Treatment Plan (PCTP) that will be customized for the BH CP program. It will incorporate all of the elements of the strength-based, recovery-oriented elements of CCBC's plan for CBFS, PACT, CSA and Outpatient clients, and will have fields that can measure client progress and outcomes. These models are Evidence-Based Practices in the Children's Behavioral Health and Adult Mental Health service delivery arenas.

The treatment plan will include fields for approval from the Assigned Enrollee; his/her identified supports, PCP, medical specialty provider, outpatient behavioral health provider, Care Coordinator, CP Clinical Care Manager and ACO liaison.

A Care Coordinator will be in charge of completing the CA and PCTP within three calendar months of assignment. CCBC's design will assign one individual to the AE, so that s/he can avoid the problem of discussing intimate details of his/her personal medical and behavioral health history to more than one person. CCBC has found that this policy greatly increases the percentage of CSP referrals that engage with the program and stay involved for the duration of the service.

The individualized PCTP will include: types, frequency and duration of services, how they will be integrated and coordinated among health care providers and how Recovery Support Navigators, Certified Peer Specialists and the Enrollee's natural community supports can enhance service delivery. Short-term goals that can provide "small wins" in the CP process as well as long term goals related to improved health outcomes, stabilization of chronic conditions and overcoming barriers imposed by social determinants of health; a crisis plan based on the Assigned Enrollee's self-identified triggers for relapse or mental health decompensation and a contact list of all involved parties with their preferred method of contact (email, text message, phone call), including the PCP and primary care giver if one is identified.

For a sample of Assigned Enrollee's, an independent member of CCBC's BH CP, a designated "Treatment Plan Facilitator," will call the Assigned Enrollee directly to ask if s/he has thought of any other need that s/he may have been reluctant to identify during the planning that the Assigned Enrollee would like to be included in the Care Plan. This emerging best practice has become standard procedure in CCBC's PACT program in order to ensure active consumer participation and ownership of their care. Any additional needs or goals that the AE identifies will be added to the Person-Centered Treatment Plan.

CCBC recognizes that some Assigned Enrollee's will have special needs and will have the capacity to translate the treatment plan into the preferred language of the Assigned Enrollee, transcribe into audio format to increase their understanding of the plans, and provide an interpreter at the meeting to communicate the content in the preferred language of the Assigned Enrollee.

3) Planned processes for updating the Person-Centered Treatment Plan.

At the conclusion of the initial PCTP meeting, the parties will agree on a follow up time frame as approved by the Assigned Enrollee. CCBC's BH CP specialized medical record will have an automated system of reminding the CP staff, PCP and Assigned Enrollee at the time that the plan needs to be updated. In routine cases, that review will be completed every 6 months. The review will include progress towards goals, reassessment of Enrollee's health status, reassessment of goals, monitoring of compliance with the PCTP, updating any new recommendations and updating the PCTP as needed based on the reassessment. The updated will be approved by the Enrollee, PCP, or designee, outpatient behavioral health provider, and any specialty providers as identified by the Enrollee.

The plan will be updated within 30 days of any inpatient admission, ED episode or major change in the Enrollee's living circumstances involving other family members, housing status, or legal involvement. The CC will emphasize the goal of supporting the Enrollee in a "continuum of stability" across all domains of the PCTP and encourage the Enrollee, providers and supports identified by the Enrollee to contact the CC if they are concerned of increasing risk to the stability of the member in any facet of the Enrollee's life, especially including areas where social determinants to care present an emerging obstacle to achievement of goals in the PCTP.

The plan will also be updated with any change in the Enrollee's status related to a progressive disease, functional decline, or resolution of a problem in compliance with section 2.3.B.2.f 1-3.

4) Planned process for ensuring the AE and the AE's PCP or PCP Designee approve the Person-Centered Treatment Plan.

CCBC will work with the Assigned Enrollee's PCP and assigned ACO to develop the most efficient means of documenting approval of the PCTP. Of course, the Assigned Enrollee's approval is paramount and will occur ideally in the meeting where all parties meet to review the plan, its implementation, and follow up. Methods of PCP approval include secure email, secure transmission through the Mass HIway, and secure texting. CCBC's EHR vendor, eHana, will have a mechanism of sharing data in place at the start of the BH CP program to expedite such communications.

3. Care Coordination and Care Management

Describe plans to satisfy the CC/CM requirements using evidence-based practices.

a. How the Bidder will identify all stakeholders

CCBC will organize the Care Team in compliance with the contract requirements in Attachment A, Section 2.3.C. We will combine our successful experience operating CBFS, PACT, CSP and CSA programs to coordinate care for enrollees with ACOs, MCOs, other health care providers, and social service agencies in a broad Care Management framework for all Assigned Enrollees referred in the Brockton, Taunton, and Attleboro areas. CCBC will use a combination of evidence based and emerging practices to address the multiple needs of Enrollees who participate in the behavioral health community partner program.

The process of assembling the list of members of the Care Team begins with the first contact with the Enrollee referred for the BH CP program. The Care Coordinator begins the initial assessment by identifying the member's strengths and preferences that include providers and other individuals whom they trust and value to help them with medical care, behavioral health treatment and community supports. The Care Coordinator will follow the practice principles of Motivational Interviewing: Express Empathy, Develop Discrepancy, Roll with Resistance, and Support Self-Efficacy: During the course of the comprehensive assessment that follows the initial meeting, the Care Coordinator will explore the Enrollee's preferred providers who are involved with the Enrollee such as his/her PCP, any specialty medical providers who are treating chronic medical conditions such as COPD, their therapist and prescriber and other community supports in the community, including relatives and friends.

If a provider of Long Term Services and Supports (LTSS) or a need for LTSS is identified, the Care Coordinator will explore the service options with the Enrollee, offering at least two LTSS resources and helping the member to choose a provider and invite that member to participate on

the Care Coordination team. The Care Coordinator will document that the Enrollee was counseled on the options for at least two LTSS providers.

The Care Coordinator will review the list of individual stakeholders with the Enrollee to help select the members of the Care Team. With a focus on the recovery orientation, the Care Coordinator and Enrollee will then list the specific roles that each member of the team can play to support the Enrollee in the execution of the PCTP. For example, a neighbor or friend can participate to accompany the Enrollee to the PCP appointment. The Recovery Support Navigator can remind the Enrollee to attend self-help meetings for substance use disorders. The PCP can review the medications to ensure that there are no contraindications.

The Care Coordinator will reach out to the potential members of the team and identify their preferred means of participating on the team and the best way of communicating with the Enrollee and all of the members of the Care Team.

b. How the Bidder will exchange information with such stakeholders.

The means of exchanging the key information among members of the Care Team will be a key component of the success of the BH CP. Timely and accurate exchange of focused information of the Enrollee's progress, transitions in care from inpatient to community settings, newly identified needs, changes in mental health status, physical health and social determinants will contribute to developing coordinated and effective interventions to address the Enrollee's complex needs. CCBC recognizes that the success of such an information exchange will be successful only if the information is easily accessible, concise and useful to the members of the Care Team. A host of options will be used including individual and group text messages, Group Chat Apps, distribution of the Continuity of Care standardized document and secure emails. CCBC will devise a method of secure communication to team members using the Electronic Highway that is compatible with the systems of the other members of the team. Absent other interface, the Care Team will devise a secure email transmission process.

c. How will the Bidder identify and organize members of the Enrollee' care team.

The final selection of members of the Care Team will emerge as the CA is completed and the PCTP is developed to ensure the role of each member promotes a recovery orientation for the Enrollee. The Care Coordinator will review the potential members of the team and their role in supporting the Enrollee and ensure that the roles of the team are aligned to encourage and develop the Enrollee's strengths, and preferences, life goals and improvement of his/her health. The follow up with the members of the Care Team will include the PCTP, the role of each member, the preferred means of communication, and the scheduled dates for follow up.

d. How the Bidder will ensure effective ongoing communication across all stakeholders, including exchanging essential documentation.

The execution of the PCTP will rely on effective communication and essential information among the members of the team who are providing the direct face-to-face services. The Care Coordinator will make sure s/he informs members of the team when the plan is implemented. This exchange assures the parties that the PCTP is being followed as planned while also inviting feedback from the members. These exchanges will take place no less than monthly and will be shared via a reminder system in CCBC's EMR.

What is even more critical is the timely exchange of information when the member's medical or behavioral health status changes, when there is a significant change in the Enrollee's life circumstance or when there is a transition of care following an inpatient admission. CCBC will establish an "Alert" communication to direct the members of the team to a secure portal such as the Continuity of Care document process via the Mass HIway, where clinical information – admission to inpatient or ED, assessment of the crisis, discharge summary and test results, revised list of prescribed medications, for example, can be shared and focused feedback from the members of the team can be solicited to strengthen the PCTP.

These exchanges will be informed by the daily triage meetings that the BH CP team will convene to review members who are at risk or whose status has recently changed. The Clinical Care Manager will work with the Care Coordinator to make sure that these updates are shared with the members of the Enrollee's Care team.

For members who are at risk of psychiatric decompensation based on prior history, the Care Coordinator will also develop a Wellness Recovery Action Plan that includes concrete steps developed by and with the Enrollee to avert a psychiatric crisis and restore the Enrollee to stability. The Care Coordinator will update the WRAP as needed following any psychiatric emergencies.

4. **Care Transitions**
   Describe plans to satisfy Care Transitions requirements using evidence-based practices, including steps to ensure EE's stability/satisfaction following transition in care.

CCBC has gained valuable experience in facilitating timely and effective Care Transitions with clients referred from their CBFS, PACT, Community Support Program (CSP) and children and families involved with CCBC's Community Services Agency (CSA). The CSP has built strong working relationships with Emergency Department staff in all four general hospitals in the Brockton, Attleboro, and Taunton areas that will mature with the implementation of the ESP in May, 2017. CCBC has assigned a dedicated onsite liaison to the discharge planning staff at several psychiatric inpatient and detox facilities in Southeastern Massachusetts. This experience provides a strong foundation for the BH CP program and will ensure that effective transitions occur for the Engaged Enrollees served by CCBC from the outset.

Planning for transitions of care from an inpatient setting begins with the Enrollee's inpatient admission. The CCBC BH CP will be able to identify admissions to inpatient psychiatric unit through reports from the CCBC ESP (that covers Brockton, Taunton and Attleboro) to the BH CP. Following the admission, the Enrollee's status will be reviewed at the daily triage meeting and the Care Coordinator/Hospital Liaison for the facility will follow up with the inpatient contact at the hospital. CCBC will expand the model from the existing relationships with Arbour Fuller Hospital in Attleboro, Morton Hospital ED, and Good Samaritan Hospital ED to ensure that a BH CP worker is available at other hospitals for transition planning. The extension of this activity at the outset will be of immediate value to the ACOs.

The lessons learned from these relationships will be incorporated into the Care Transition activities of the BH CP that meet all of the requirements of Attachment A, Section 2.3.D:

- Successful Care Transitions rely on client engagement based on the strengths and recovery-oriented treatment plan develop with the Enrollee.
- Established methods of communication build on continued relationships and timely follow up with the Enrollee within three days of discharge.
- The trust with an inpatient program grows with a staff person from the BH CP designated as the transition of care contact for each hospital. This designated individual aligns with the Health Home licensing standards in Rhode Island, an emerging best practice, where the required staffing model includes a Hospital Liaison.
- Timely sharing of information by the community-based provider with the inpatient provider becomes a foundation for timely transitions of care.

CCBC will enhance the lessons learned by incorporating the use of the Continuity of Care document that is part of the Mass HIway data exchange into the BH CP. The program will also have improved communication with the Steward Health system that operates Good Samaritan and Morton Hospitals as part of CCBC's role as an ESP in the Brockton and Taunton-Attleboro areas and five separate ICB grants with Steward, the last two with Steward as a pilot ACO. The BH CP will assign a hospital liaison to the medical surgical units at these hospitals to meet the requirements of Attachment A, Section 2.3.D. The assigned liaison will be able to participate in the discharge planning from the Medical-Surgical units at these two hospitals.

In order to meet the other requirements of Attachment A, Section 2.3.D., the Care Coordinator will take the following steps following the admission:

- Inform the members of the Care Team of the admission, including the trigger for the admission;
- Work with the inpatient providers to identify their intervention and preliminary discharge plan;
- Send a follow up a communication to the members of the Care Team identifying needs for the transition of care as it affects the team members including appointments following discharge;
- Attend the discharge planning meeting;
- Communicate the transition plan to the members of the team and the follow up appointments, including a face-to-face meeting with the Enrollee within three days of discharge;
- Ensure that the Enrollee has access to needed community resources at the time of discharge; and,
- Work with the Enrollee to revise the PCTP as informed by the inpatient admission and discharge plan

The Care Coordinator will also act as the liaison to the ACO (already established if the Enrollee is at a Steward facility, including Steward inpatient psychiatric units at Norwood Hospital Carney Hospital, St. Elizabeth's Hospital, or Holy Family Hospital. CCBC will work with Steward on adapting the "Steward Transitions Follow up Assessment" form for BH CP members who transition from inpatient or ED utilization back to community settings.

The Care Coordinator will prepare a brief summary of the inpatient episode that will be distributed via the Mass HIway or by secure email to the members of the team. The summary will include:

- Reason for admission including precipitant;
- Stabilization interventions during the admission, including any new findings from the inpatient assessment;
- Plans for discharge and revised roles for members of the Care Team;
- Updates in medications, including verification of a review by the RN on the BH CP team;
- Schedule for appointments at discharge and links to flexible and natural community supports;
- Enrollee strengths and resources identified to enhance stability at discharge;
- Updates in the crisis plan section of the EE's PCTP to prevent future escalations and admissions.

The BH CP will assess the effectiveness of the Enrollee's adherence weekly in the first six weeks after discharge, then monthly if the Enrollee is accessing supports, demonstrating adherence, and showing no negative side effects or complications. Any issues will be brought to the community prescribers and an Ad Hoc Care Team meeting will be called to address the preferences of the Enrollee around any changes.

5. **Medication Reconciliation**
   Describe plans to satisfy the MR requirements using evidence-based practices.

CCBC views strong working relationships with the ACOs as a key fundamental to meeting the contract requirements in 2.3A. CCBC's working relationship with the Steward Health System's ACO already will include methods of communicating to the BH CP when an Enrollee is discharged from one of Steward's inpatient psychiatric units, inpatient medical-surgical units or one of Stewards Emergency Departments. Working closely with Steward, CCBC will adapt the medical record to allow for secure electronic communication from the Steward EHR to CCBC BH CP on the medications prescribed at discharge as well as the prescriber who will follow up on the medications: the Steward PCP, the outpatient psychiatrist, or the specialty medical provider in the Steward system.

CCBC will seek to establish the degree of electronic exchange with the BMC, BMC-Southcoast and Community Care Collaborative ACOs for members of their ACO who are hospitalized in their facilities.

CCBC recognizes that supporting the Enrollee's adherence with the prescribed medications can be a challenge. Barriers to medication adherence are complex and varied; solutions to improve adherence must be multifaceted. The CCBC CBFS and PACT programs have developed best practices to ensure compliance that will be adapted for the Enrollees in the BH CP. They include:

- working with providers to simplify complex dosing and medication regimes,
- clear directions to the Enrollee on the purpose of the medications;
- support for the Enrollee to follow the regimen;
- connecting enrollees with full service pharmacies;
- coordinating simplified medication management packaging with organized medications delivered each month;

- associating enjoyable activities with the medications using techniques of CBT, DBT, and person-centered, recovery-oriented engagements, and,
- aligning the practices of the MAP with the reconciliation at discharge.

The CCBC BH CP will establish the following program standards to meet the requirements of Attachment A, Section 2.3.E.:

- As part of the follow up within three days of discharge, the Care Coordinator will verify that the medications received at the time of discharge aligned with the discharge summary and the prescriptions have been filled. The clinical nurse of the BH CP will be available for any back-up consultation if needed
- The discussion with the Enrollee will also include a review of the methods of administration of the medications – amount, time of day of administration and other conditions such as with or without food – to make sure any questions are addressed.
- The BH CP Nurse will address any contraindications with the prescribers by the BH CP Clinical Nurse and addressing the issues with the Enrollee
- Developing a follow up plan to support the Enrollee's adherence to the regimen with natural community supports, home health providers, and the Enrollee's preference for communication with the Care Coordinator (via text or Chat App, for example) to maintain communication in a manner preferred by the Enrollee
- Communicating with CBFS providers who are using a Medication Assistance Program (MAP) model to complete the required forms from the Enrollee's PCP or discharging prescriber.

6. Health and Wellness Coaching

Describe plans to satisfy Health and Wellness coaching requirements using evidence-based practices.

a. Health and wellness education, coaching and health promotion programs the Bidder intends to utilize or follow

CCBC recognizes the shortened life expectancy of persons with SPMI who will be among the populations participating in the BH CP. Co-Occurring chronic medical conditions such as COPD, Diabetes and Obesity are common among clients in CCBC's CBFS, PACT and outpatient programs. Psychopharmacological treatments often add to the burden of these conditions. Smoking, poor diet and infrequent exercise are part of the lifestyles that exacerbate these conditions and increase risk.

The BH CP will provide a wide range of health and wellness education, health promotion and client activities that address Enrollees' chronic health conditions and lifestyles. The BH CP will incorporate Enrollees into two Evidence-Based Practices that CCBC already operates:

- The evidence-based "InSHAPE" program that introduces Health mentoring and coaching to clients in the DMH-contracted CBFS program. The In-Shape program is a nationwide study organized by the Giesling School at Dartmouth's School of Medicine. Enrollees will have access to Health Mentors who can work with the PCP to customize an assessment as that can identify health and wellness goals as part of the Enrollee's overall Person Centered integrated plan of care. The BH CP will identify barriers and opportunities to improve health and wellness, work with the Enrollee to identify coaching opportunities and develop a plan for

participation in the InSHAPE program. InSHAPE participation focuses on wellness group opportunities and peer-run programs that will include mall walks, use of the local YMCA's in Brockton, Taunton and Attleboro for a range of activities based on individualized needs, sporting groups (basketball leagues, softball groups) healthy cooking groups, and on-site nutrition education including seasonal visits to the Brockton, Taunton and Attleboro Farmer's Markets which specialize in locally grown, fresh fruit and vegetables.

- The evidence-based Illness Management and Recovery program, currently in operation at CCBC, will use the stress vulnerability model to educate the BH CP Enrollees on the impact of exercise, nutrition, and sleep on both intensity and frequency of symptoms. Poor nutrition, sedate activity, and poor sleep hygiene are identified as barriers to reaching personal goals. Through Motivational Interviewing techniques and psychoeducation, EE's are provided with support, information and tools to develop and implement wellness plans and make incremental changes to allow for improved physical and psychiatric health. Through the encouragement and support of peers and trained staff, EE's implement and progress through self-defined wellness goals.

The BH CP staff will engage the Enrollees in these Health and Wellness activities using a variety of different methods: group education sessions, individual coaching sessions, "learn by doing" activities involving cooking, shopping and gardening, and exercising, viewing videos, and presentation of written materials.

- The Enrollees will also have access to the nutritional counseling and wellness programs at area hospitals – Morton in Taunton, Good Samaritan in Brockton, and Brockton Hospital in Brockton – and similar activities at the Brockton Neighborhood Health Center, a provider who has agreed to host activities involving their clients enrolled in the BH CP. These programs include smoking cessation and weight loss.

- CCBC will include the BH CP Enrollees in the supplemental SNAP purchasing program that incentivizes purchases at participating local Farmer's markets in Brockton, Taunton and Attleboro where EEs can purchase fresh fruits and vegetables, and support cooking and eating habits. Access to Farmers Markets is important in Brockton and Taunton, which have been designated as Food Deserts by DPH.

CCBC will set up new programs for the BH CP Enrollee that follow the fidelity standards of the existing In-Shape and IMR group activities where the peer to peer engagement has proven to be a more sustaining and successful tool in engaging other clients.

The CCBC BH CP will train the RSNs, CPSs and Care Coordinators in health and wellness coaching the Enrollees as distinct from counseling, therapy or case management.

b. Methods for ensuring EE's goals for the health and wellness programs are recorded and tracked in EE's Person-Centered Treatment Plan.

The individualized needs of each Enrollee for health and wellness coaching will be identified in the PCTP. The Care Coordinator and Clinical Coordinator will match the psychiatric symptoms to their lifestyle, including nutritional habits, use of leisure time and approach towards exercise.

The Coach will work with him/her to select a set of health and wellness goals that are based on their preferences, lifestyle, learning style and community supports.

The PCTP includes a section that addresses healthy activity, nutrition awareness, wellness promotion, and use of leisure time. Care Coordinators will be trained to link any recommendations in the PCTP to the Engaged Enrollee's identified preferences in from the different program option listed above.

During the quarterly review of the Enrollee's participation in the program, the Care Coordinator will consult with them and his/her health and wellness Coach to assess his/her participation in the health and wellness activities. The Care team will take notice of accomplishments and revise the plan if necessary to accommodate the Enrollee's changing needs and provide additional support where needed. The CC will also work with the Enrollee's PCP to reinforce the EE's progress and success. CCBC has found that the PCP's are active participants in the planning, design and delivery of health and wellness programs for the current population of In-Shape and IMR participants.

The coaching activities will be provided by Care Coordinators, Recovery Support Navigators and Peer Specialists as developed and identified in the comprehensive assessment where the natural supports, lifestyle, cultural identify with food and lifestyle of the Engaged Enrollee will be considered in an individualized plan for health and wellness.

7. **Connection to Community and Social Services**
    a. **Plans to evaluate EEs for social service needs.**

CCBC's mission and vision are directly connected to addressing the social service needs of its clients and connecting them to such resources as part of the client's plan of care. As a community agency, CCBC has evolved its mission to address broader community needs related to homelessness, HIV and opiate abuse among others. Through this community participation and leadership, CCBC has earned a strong reputation as a community leader by initiating coalitions to address homelessness, opioid overdoses, and the spread of HIV. By seeking funding and implementing programs in the area of affordable housing, as one example, CCBC earned an award from the Association of Behavioral Health Providers (ABH) as a best practice provider. The inclusion of evaluation of the members of the BH CP for social service needs is integral to CCBC's entire program and will continue with the BH CP.

It is standard practice in all of CCBC's clinical and social service programs to assess the client's social service needs through a person-centered focus. The assessment will explore the Engaged Enrollee's (EE's) connections to his/her community, including identified culture, religion and family, client and family safety, goals for independence, including employment, education and financial independence, and access to natural community supports. CCBC recognizes the importance of social determinants in improving a member's mental and physical health and from its perspective as a community mental health provider has undertaken a substantial role to develop resources to address other community issues such as affordable housing, substance use disorder prevention services, and elder outreach. Through these efforts CCBC managers and staff are very visible in the community as participants in coalitions, task forces and advisory groups at the city, county and regional level.

CCBC's assessment tool for BH CP will address the bio-psychosocial factors in the client and his/her family including social determinants such as cultural background, lack of secure and safe housing, domestic violence, involvement with the criminal justice system. The presence of any one of these can be barriers to accessing and receiving adequate health care and can interfere with a client's recovery from mental health and substance use disorders. CCBC's assessment will identify barriers and aids in the EE's social environment, especially natural community supports.

b. How CCBC will ensure CCs are familiar with a wide breadth of social services and supports, and providers of these supports.

A key element of the orientation for a new CCBC employee is exposure to the full range of CCBC programs and local affiliations. The BH CP staff will be part of all staff meetings and managers' meetings where these programs are discussed, data shared about their performance, and improvements in operation are developed. The BH CP program will provide another perspective on how to connect CCBC clients to these resources.

All new employees are oriented to the full spectrum of CCBC's programs and community presence on task forces and coalitions related to housing, prevention of overdoses, community education about HIV, and diversion from the criminal justice system of persons with mental health or substance use disorders and how they can access supports and resources for the Enrollees in the BH CP program. A successful strategy that has been used in our CSP program will also be the opportunity for Care Coordinators to shadow current CCBC CSP staff to observe their techniques for engagement and relationship building with clients as well as developing resources in the community as a part of their initial training.

c. Planned strategies for collaborating with ACOs to recommend Flexible Services on behalf of EEs, and following-up on the outcomes of such supports.

CCBC has already developed and implemented strategies of collaboration with the Steward Pilot ACO in an ICB grant in 2016. The working relationship to address members' social services will be strengthened in the current round of ICB that is operating from March-July, 2017. In this engagement, CCBC's CSP workers are focusing on 100 clients who fit the profile of potential BH CP Enrollees or members at high risk as identified by Steward. A key outcome measure for this program will be to assess how the participants accessed flexible supports identified in the plan of intervention jointly developed among the client, CCBC staff and Steward PCP's.

CCBC's CSP program is also an active participant in a number of forums in Brockton that strategize on providing social and flexible supports to community members that include:

- "Citizen X" forum convened among ED staff, DMH, outpatient providers, the Brockton police department, and the CCBC CSP program.

- Other areas of collaboration include the Veteran's Forum that focuses on homeless veterans and other community members, CBFS and PACT Client Forums, convened by DMH's Brockton Area Multi-Service Center.

- Informal client-specific interventions with the Brockton Haitian Club and Cape Verdean Society to provide support and assistance to specific members' needs related to housing, enrollment in MassHealth, and legal representation on immigration matters.

In these settings, CCBC staff join Good Samaritan Hospital, Brockton Hospital and Brockton Neighborhood Health Center in solving individual member issues. These relationships will provide a solid foundation for the CCBC BH CP to help EE's from Steward ACO, BMC ACO at Brockton Hospital and CCC at Brockton NHC access flexible community services. The BH CP Care Coordinators will join these meetings. CCBC is also Designated Certified Application Counselor Organization for MassHealth and The Health Connector in Brockton, Taunton and Attleboro.

7.3 D. Innovative technologies for service delivery

- CCBC was one of the first providers in MA to adopt the eHana Electronic Health Record and has partnered with them in the evolution of the clinical record that incorporates the MA Standard Documentation Plan (MSDP) for clinical assessments, treatment planning and documentation of client progress.
- CCBC and eHana will partner with the BH CP initiative to create a care management module customized for the BH CP program. It will feature seamless information sharing with ACOs, with other BH CP's who use eHana, and with the Care Managers from the MCOs.
- Configurations to send CA, PCTP, and client status updates via secure email to members of the Care Team over the Mass HIway;
- The Care Management module will incorporate the Continuity of Care document that is critical to Transitions of Care. It will contain and include medication and direction from administrator.
- An event notification system that serves "Alerts" from an ACO provider to the BH CP. An Engaged Enrollee will be "tagged" so that when the Enrollee is entered into the ACO hospital ED, the BH CP or other member of the Care Team will receive an electronic alert so that on-call staff can mobilize/collaborate with the ED and CCBC ESP or other programs to intervene. After 8 p.m. and weekends the alert will go to the ESP which has 24/7 awake staff.
- Linkage between BH CP clients with the CCBC ESP database, so ESP staff can notify the BH CP when a BH CP client presents for an ESP evaluation.
- Mobile Outreach and Engagement: CCBC anticipates deploying mobile "apps" to support its staff in the enrollee outreach process. Such apps could be used by Care Coordinators to (a) identify enrollees requiring outreach and follow-up, (b) access contact information (phone, address), and (c) document service activities. Activity would be synchronized with the centralized Care Management platform for review by supervisors and Care Team members.
- Social Outreach and Engagement: CCBC is exploring leveraging social networking tools to engage with Enrollees. Techniques could include leveraging Facebook's Messenger Platform Application Programming Interface (API) to supply enrollees (or their authorized representatives) with our chat name and a unique code, which would automatically associate their Facebook Messenger account with their Care Management record. Enrollees could then outreach to the Care Team at any time via the Messenger app already installed on their phone, notifying their team and prompting engagement in real-time (providing appropriate consents were in place and with necessary checks to ensure no PHI was exchanged).
- CCBC will develop customized phone applications, or "apps" that the Engaged Enrollee will be able to adapt to his/her needs in support of the goals of the PCTP. These apps include "My Strength" that focuses on the needs of individuals with SMI. For clients with special needs for Health and Wellness identified in PCTP, CCBC will have FitBits to help Engaged Enrollee track physical activity and provide reminders on established goals.
- In two focus groups with CCBC clients, there were preferences for dedicated smart phones that allowed direct lines to CCBC staff and programs, the ESP, and other community supports. Another application was a link to de-escalation protocols related to breathing, finding a quiet space in the midst of confusion, repeating from a list of affirmations, or helping the Engaged Enrollee find a 12-Step Group, DRA Group, or other identified group.
- CCBC will also work with the Engaged Enrollees, ACO's and other community providers in developing customized Facebook pages, Twitter accounts and Instagram applications to offer opportunities for informal, collegial peer communication to support health lifestyles, crisis support and shared group activities.

7.3 E. Personnel and Staffing

Provide a proposed staffing plan to perform Contractor Responsibilities, including implementing the scope of CP Supports and administrative aspects of the Contract.

1. **An organizational chart that identifies personnel, senior managers, and other staff by title to be assigned to accomplish Contractor Responsibilities.**

   (See attached)

2. **A sample staffing model for the number of EEs in each Service Area, including number of full-time equivalent (FTEs) for supervision, administration, and Care Management and Care Coordination positions.**

CCBC has designed a sample staffing model to serve 1,000 Engaged Enrollees in the combined Taunton-Attleboro Service Areas and 1,000 Engaged Enrollees in the Brockton Service Area. The qualifications for the Care Coordinators will be Bachelor Degrees in human services or related fields with relevant experience and duties similar to the CCBC CSP staff. Among these Care Coordinators CCBC will recruit at least two Recovery Support Navigators and two Certified Peer Specialists for each program to ensure a peer support capacity for the Engaged Enrollees.

The BH CP supervisors will each manage eight Care Coordinators. While a Master's degree and an independent license are preferred, they are not required. However, CCBC will hope to fill at least one of the supervisory positions with an R.N. or a Masters level clinician. The Clinical Care Manager will be an R.N. or an independently licensed behavioral health clinician with principal responsibility for all PCTPs, CAs, and compliance with all of the program requirements for Care Coordinators. The BH CP Program Director will be responsible for quality management and reporting and represent the BH CP to the ACOs and MCOs who share Engaged Enrollees, and to MassHealth. The Program Director will report to the Vice President of Integrated Care.

Most of the administrative duties of the BH CP such as scheduling, billing, IT management, data entry and reporting will be incorporated into CCBC's existing administrative structure after start up. However, an administrative staff person will be on site at the Brockton program to compile site-specific information that will be forwarded to the CCBC's administrative office. CCBC maintains a site-based scheduling system to match client requests with available staff to ensure prompt response to requests from Engaged Enrollees, PCP's, hospital emergency departments and inpatient units, representatives from community agencies, and other behavioral health providers. If one site is not available, the phones will switch to the other site for live voice response.

CCBC will assign a half-time data analyst/quality manager to the BH CP to oversee the implementation of the customized care management module with CCBC staff, incorporate information sharing with the ACO and MCO data profiling and utilization history information systems, and facilitate information sharing with other providers including PCP's, hospitals, other behavioral health providers and social service organizations. The analyst will also work with CCBC's Director of Compliance and Quality Management to set up the data entry and reporting for the quality metrics.

As the Care Management module becomes streamlined and as BH CP staff develop competencies in timely exchange, service gap identification and population health analysis that are all aligned with the operation of the ACO, CCBC expects that this position will be integrated into the analytical activities of the ACOs by Year 3.

The BH CP will have access to psychiatric consultation from Paul Weiss, M.D., the Medical Director at CCBC, or his designee. CCBC maintains 24/7 psychiatric coverage as well as on call back up from program managers and CCBC senior clinical managers.

3. **Description of recruitment plans, including timelines to recruit staff for personnel positions not filled, and job descriptions/qualifications for each personnel position.**

Recruitment Plan: CCBC is experienced with new program implementations of this size and scope. We have had success in recruiting and retaining Care Managers for the Community Support Program (CSP), Family Partners and Individual Care Coordinators for the Community Support Agencies, and line staff for the CBFS and PACT programs. CCBC recognizes that this recruitment effort will require a detailed staffing plan that involves CCBC managers, HR staff, and CCBC recruiter, with active outreach to the pools of applicants in Bristol County, Attleboro, Taunton and Brockton, and postings on employment Web Sites used by CCBC. It should be noted that the workforce will ramp up over time as Engaged Enrollees are assigned to the program. Our understanding is that this process would take up to 15 months.

Local resources with potential pools of applicants include:

- Massasoit Community College in Brockton and Bristol County Community College campuses in Fall River, Taunton and Attleboro, to recruit among current students and recent graduates with AA degrees in human services.
- Bridgewater State University
- University of Massachusetts, Dartmouth
- Stonehill College
- DES Offices in Brockton, Taunton, Fall River and New Bedford
- DMH Recovery Learning Communities (RLCs) in Brockton and Taunton
- Outreach to coalitions in which CCBC is involved in Taunton, Attleboro, Brockton and Bristol County.
- Web sites where CCBC posts open positions include: Indeed, Indeed OnLine, and Monster.com. CCBC also retains Bayard Consulting to create landing pages and draft job descriptions for on-line recruitment and for CCBC's Facebook page recruiter for management level positions. CCBC will retain Robert Half Recruiting Agency to identify candidates for the data analyst position.

Timelines to Recruit Staff:

Upon notification of award:: Informal Recruiting for Program Directors and Supervisors
1/2/2018: Formal Recruiting–posting on websites, notices at local colleges and DES offices
1/9/2018: Interviews begin
2/2/2018: Offers extended and accepted

3/1/2018: Initial group of staff hired. Target hiring is one clinical care manager, , one BH CP Program Director and one RN.

3/1/2018-3/31/2018: Interviewing and hiring remaining prep budget period staff. Target hiring is two supervisors, 16 Care Coordinators, one Recovery Support Navigator, one Certified Peer Coordinator and one Data Specialist.

6/1/2018 –

3/1/2019: Ongoing recruiting, interviewing, and hiring to build capacity for providing BH CP services. CCBC expects to start the month of June 2018 by receiving a total of 640 assigned clients. The projection for new assigned clients for July 2018 is 283 and 80 assigned clinets for August. September and October 2018 assignment will increase to an average of 120 per month. November and December assignment will increase to an average of 160 per month. Assignments per month from January 2019 to June 2019 is expected to be at 200 per month. Assignments per month from July to December 2019 are expected to be 160. With this volume of assignments and the expected level of enrollments CCBC projects to have to reach 2,000 enrollees by December 2019.

CCBC will hire this initial complement of Clinical Care Manager, RN and a Program Director by February 1, 2018. Together they will work to design a BHCP Orientation Plan, develop workflows, program planning and interview and train new staff. They will begin outreach on June 1, 2018. The staff that are hired after March 1, 2018 will be orientated to the BHCP, begin training; some staff will receive CHW training. These staff member will begin outreach on June 1, 2018.

CCBC will scale up staffing as potential enrollees are identified, contacted and engaged. Our estimated targeted is 640 new assigned clients beginning on June 1, 2018. CCBC will be hiring Care Coordinators over a two month period (April and May 2018) therefore the budget reflects a total FTE of 12. However on June 1, 2018 CCBC will have a staff of 16 Care Coordinators who have been trained and oriented to conduct outreach and engagement activities, complete Comprehensive Assessments, PCTPs and Care Coordination activities. By hiring staff up to two months before implementation, the BH CP staff will develop competencies in operating the care management module, establish working protocols with the Care Management representatives at the ACOs and MCOs, and develop a common clinical understanding of the BH CP members identified by MassHealth.

7.3 E. 3 Attachments: Job Descriptions and qualifications for BH CP Program:

- Program Director
- Clinical Care Managers
- Supervisor of Care Coordinators
- Care Coordinator
- Recovery Support Navigator (RSN)
- Certified Peer Specialist (CPS)
- Nurse

4. A description of how the Bidder will recruit and hire staff from the cultural and linguistic communities they intend to serve.

CCBC has a strong record of hiring staff that represent the diverse communities in Taunton, Attleboro and especially Brockton. CCBC's working relationships with adult education organizations, the YMCA, the Cape Verdean Association in Brockton and the Haitian Center in Brockton, will provide a foundation for grass roots, outreach approach to potential candidates for the BH CP program positions. CCBC will develop materials for both a presentation and brochures in Spanish, Portuguese, and French Creole as part of the recruitment effort to these diverse communities. Informal outreach will also occur through CCBC's participation on community-based task forces related to housing, suicide prevention, opiate abuse prevention and the Prevention and Wellness Network.

5. Proposed training, orientation plans and modules for staff.

CCBC has established a process for training and evaluating all staff based on a set of core competencies for each program type. CBFS, PACT, and Supportive Housing have developed core competencies that are centered on case management, rehabilitation and recovery services. A specific training program for the BH CP program staff will be developed, incorporating many of the modules used for these programs along with the agency's comprehensive orientation process.

The Care Coordinator Orientation and Training Program would include CCBC's Relias online system which offers over 600 courses, in person onsite training, and offsite external trainings.

An overview of the modules is presented below:

Agency Orientation

- CCBC Orientation-one full day completing Human Resources and policy and procedures
- CCBC Mission, Vision, Values
- Completion of new hire requirements
- Orientation to electronic health record

Program Orientation and Training

- Developing the Comprehensive Assessment
- Documenting the Person-Centered Treatment Planning Process
- Principles of Supportive Case Management
- Principles of recovery from addictions/co-occurring disorders
- Maintaining effective/appropriate boundaries with clients
- Overview: Principles of psychiatric rehabilitation/recovery (in-person)
- Overview: Serious Mental Illness for paraprofessionals (Relias)
- Overview: Substance Use Disorders (Relias)
- Co-Occurring Disorders: Overview for paraprofessionals (Relias)
- Relapse Prevention Services: Treatment Best Practices (Relias)
- Suicide Screening/Risk Factors (Relias)
- Advanced Suicide Prevention (in-person)
- Seeking Safety (in-person)

- Motivational Interviewing (Relias)
- Person Centered Planning (Relias)
- Opioid Overdose Prevention (in-person)

Safety Training:
- Risk management and safety protocols
- Use of 5 Star safety devices
- CPI Training (in-person)
- CPR/First Aid (in-person)

6. Description of staff retention strategy.

CCBC's staff retention strategy includes the following:
- A generous benefits package
- Access to Relias Training for a broad menu of free trainings for CEUs, career advancement and related professional and career topics.
- An active policy of recruiting from within to encourage staff to apply for higher level positions.
- An Employee Assistance Program that is independent and confidential for all CCBC employees
- Opportunities that CCBC can offer as an employer of over 500 delivering a range of behavioral health care services.
- Fidelity to an exit interview process that provides CCBC managers with important feedback on how to manage their workforce more constructively and promote retention.
- Support to continue education and annual support through tuition reimbursement to underwrite the cost for those pursuing undergraduate and graduate education.

7.3. F. Implementation Plan and Timelines – Attachment

Attach timelines that display monthly implementation plans for Preparation Budget Period, and quarterly plans for each subsequent Budget Period. (Included Below)

Implementation Plan and Timeline: Preparation Budget Period

CCBC's implementation plan reflects a dynamic process encompassing start-up and ongoing operations activities. The agency has an established, proven model for effective program implementation which mobilizes senior management, finance, human resources, medical records, facility, and consultative resources all working toward a successful launch of the Behavioral Health Community Partner (BH CP) services. By moving forward with the implementation plan outlined in this section, CCBC will be able to achieve a fully operational service by June 1, 2018.

Human Resources:

Tasks	Operational Action Steps	Start Timeframe	Completion Timeframe
Staffing and recruitment plan	Review and enact hiring plan • Activate hiring strategies including range of advertising mediums	Upon award of contract	May 2018
Job descriptions and qualifications	Review and finalize	Upon award of contract	February 2018
Training and orientation plan	Review and finalize	Upon award of contract	March 2018
By position recruitment and hires:	Program Director	Upon award	February 2018
	Clinical Care Manager (1 FTE)	Upon award	February 2018
	RN(1 FTE)	Upon award	February 2018
	Supervisor(2 FTE)	Upon award	May 2018
	Care Coordinators (16 FTE)	Upon award	May 2018
	Recovery Support Navigator (1 FTE)	Upon award	May 2018
	Certified Peer Coordinators(1 FTE)	Upon award	May 2018
	Data Specialist (.5 FTE)	Upon award	May 2018

Quality Management:

Tasks	Operational Action Steps	Start Timeframe	Completion Timeframe
Quality Improvement Committee	Convene committee • Review BH CP Operational elements	May 2018	Ongoing
Quality Measures	Review, train, and test	May 2018	August 2018
Performance Results	Review outputs	September 2018	Quarterly
Consumer satisfaction survey	Develop survey tool	August 2018	Semi-Annual Starting Dec 2018

Billing and Financial Accounting:

Tasks	Operational Action Steps	Start Timeframe	Completion Timeframe
Ensure Readiness of Billing and Accounting Structures	Review billing and EHR systems	Upon Award	May 2018
Supplier Diversity Plan	Review and enact	Upon Award	May 2018

Information Technology:

Tasks	Operational Action Steps	Start Timeframe	Completion Timeframe
Review EHR readiness	• Hardware • Billing • Customer Service • Care Planning • Provider Rosters • Financial Systems • Quality Measurement • Reporting	Upon Award	May 2018
Output and Access Review • ACOs • MCOs	• Receiving info • Creating Info • Accessing Info • Storing	Upon Award	March 2018

• EOHHS • Other Providers	• Transmitting		
Mass Hlway integration via DirecTrust HISP"	Assess readiness	Upon Award	May 2018
System Security	Review and test	Upon Award	May 2018
Review of tech tools and adaptive technologies	Implement	Upon Award	May 2018

Consumer Advisory Board:

Tasks	Operational Action Steps	Start Timeframe	Completion Timeframe
Membership	Approach and secure commitments from identified members	Upon award of contract	June 2018
Meeting Schedule	Convene first meeting	September 2018	Ongoing
Meet with Leadership	Review how board input will be incorporated into planning and operations	September 2018	Ongoing

Training Plan:

Tasks	Operational Action Steps	Start Timeframe	Completion Timeframe
Training Schedule	Finalize Agenda Topics: • Orientation • Outreach and Engagement • Comprehensive Assessment • Person-Centered Treatment Planning • Care Transitions • Medication Reconciliation • Health and Wellness Coaching • Community Connections • Integrated Care • Community Resources • Evidence-Based and Emerging Practices • Other Topics as listed in the Training Section 7.3E	May 2018	Ongoing

Implementation Plan and Timeline: Quarterly

Following the enactment of the Preparation Budget Period Implementation Plan, CCBC's Quarterly Implementation Plan will naturally follow the outlined areas from the original plan, ensuring completeness, quality control, efficacy, and stakeholder satisfaction while setting the stage for operational sustainability going forward. Each area will be reviewed on no more than a quarterly basis following the completion of the 7 month initial period ending December 2018.

Human Resources:

Tasks	Operational Action Steps	Start Timeframe	Completion Timeframe
Staffing and ongoing recruitment	Review and hiring to date and remaining positions to fill. Positions will be added as indicated by client additions and staffing ratios.	January 2019	ongoing
Training and orientation	Update training and orientation plan	January 2019	Semi-annual
By position recruitment and hires:	Care Coordinators: Additional to original 16: July 2018: 1 hires August 2018: 3 hires September 2018: 4 hires October 2018: 3 hires November 2018: 2 hires December 2018: 4 hires Supervisors: June 2018: 1 hire September 2018: 1 hire December 2018: 1 hire RNs: June 2018: 1 hire August 2018: 1 hire November 2018: 1 hire		December 2018

Quality Management:

Tasks	Operational Action Steps	Start Timeframe	Completion Timeframe
Quality Improvement Committee	Quarterly committee meetings • Review BH CP Operational elements		Ongoing
Quality Measures	Review and update		Ongoing
Performance Results	Review outputs		Quarterly
Consumer satisfaction survey	Develop survey tool		Semi-Annual Starting 12/18

Billing and Financial Accounting:

Tasks	Operational Action Steps	Start Timeframe	Completion Timeframe
Monitor Billing and Accounting Structures	Continuous review of billing and EHR Systems		Ongoing
Supplier Diversity Plan	Continue to implement		Ongoing

Information Technology:

Tasks	Operational Action Steps	Start Timeframe	Completion Timeframe
Review EHR Performance	• Hardware • Billing • Customer Service • Care Planning • Provider Rosters • Financial Systems • Quality Measurement • Reporting	January 2019	Quarterly and ongoing
Review Output and Access Review • ACOs • MCOs • EOHHS • Other Providers	• Receiving info • Creating Info • Accessing Info • Storing • Transmitting	January 2019	Quarterly and ongoing
Review Mass Hlway integration via DirecTrust HISP"		January 2019	Quarterly and ongoing
Review and update System Security		January 2019	Quarterly and ongoing
Review and update use of tech tools and adaptive technologies		January 2019	Quarterly and ongoing

Consumer Advisory Board:

Tasks	Operational Action Steps	Start Timeframe	Completion Timeframe
Membership	Update membership	January 2019	Quarterly and ongoing
Meet with Leadership	Review how board input will be incorporated into planning and operations	January 2019	Quarterly and ongoing

Training Plan:

Tasks	Operational Action Steps	Start Timeframe	Completion Timeframe
Training Schedule	Update and Assess Agenda Topics: • Orientation • Outreach and Engagement • Comprehensive Assessment • Person-Centered Treatment Planning • Care Transitions • Medication Reconciliation • Health and Wellness Coaching • Community Connections • Integrated Care • Community Resources • Evidence-Based and Emerging Practices • Other Topics as listed in the Training Section 7.3 E	January 2019	Quarterly and ongoing

7.3. G. Budget Report and Budget Narrative – Attachments
Budget Report – Attachment B
Budget Narrative – Attachment C

7.3. H. Sustainability

Provide a description of plan to sustainably fund proposed infrastructure and capacity building investments and CP Supports over the Contract Term and after the initial Contract Term. Such description shall include a description of any tools, resources, or processes the Bidder intends to develop using DSRIP funds and continue to maximize after the initial Contract Term.

CCBC recognizes the requirement from CMS to demonstrate long-term sustainability of the BH CP program as an integral component of the 1115 waiver and the ACO initiative. CCBC believes that its five-year business plan will put the BH CP program on a strong footing to maintain the infrastructure investments, reduce overall administrative burden, strengthen the BH CP program's capacity to improve Enrollee outcomes, reduce total cost of care and sustain the BH CP program beyond the five-year window.

DSRIP funding will be focused on three areas of infrastructure development:

- Adding a BH CP Care Management EMR as a compliment to the current eHana Electronic Health Record for CCBC clients. This module will have the capacity to send and receive information with ACOs, MCOs and individual practitioners who participate in the BH CP Care Teams.
- Developing analytic capability to track member utilization, health outcomes, and patterns of care that can predict risk for high utilization or trend towards recovery and stability.
- Training for BH CP staff on Motivational Interviewing, Bidirectional Health Care Navigation, Health and Wellness Coaching, and Recovery Supports.

CCBC expects substantial one-time cost for software and hardware related to the infrastructure development with declining licensing and maintenance costs over time. After the care management software is fully operational and meets all specifications, the cost will become part of CCBC's administrative overhead and incorporated into the current maintenance agreement with eHana. Also, part of the DSRIP Business plan will be the hiring of staff and contractors to assist with the data analysis required for reporting to MassHealth and tracking utilization with the ACOs and MCOs. However, as the program managers gain competencies and strengthen relationships with the ACOs and MCOs, the analytical resources will be reduced and ultimately assumed by the health population analysts within the ACOs and MCOs. CCBC will maintain analytic competencies among BH CP managers and quality management staff.

The training costs are relatively inexpensive per staff, so as the BH CP achieves full staffing the training costs for the program will be reduced. A goal is to standardize training of the ACO staff with the BH CP staff and deploy subject matter experts within the BH CP to implement the Train the Trainer Model after in Year 2 of the program.

The key to ongoing sustainability will be the degree to which the BH CP, ACO, MCO and community providers embrace the transformation of the care delivery model. As a key participant CCBC will contribute to the sustainability through the re-organization of its practice model and by taking advantage of new technologies, APM's, and data analytics to streamline care and improve outcomes. Elements of the sustainability plan include:

Improved efficiency of sharing timely information to engage and treat the EE at the right time with the right providers and according to the needs identified in gaps of care in a way that expands competency in interpreting the patterns across all the providers.
Improving efficiency of scheduling to reduce missed appointment, repeat tests, minimization of duplicate prescriptions, and increased triage of EE's to outpatient and urgent care on a routine basis as alternatives to the ED\ and inpatient.

Through demonstrated value of improved client outcomes and reductions in total cost of care, CCBC's BH CP will negotiate with the MCO's for expanded delegation to the BH CP program as a Practice-Based Care Management program, shifting the capitation paid to the MCO for these care management services to the CCBC BH CP, resulting in a reduction of MassHealth's overall cost. As research has shown, a competent practice-based program will have the highest rate of member engagement resulting in the delivery of cost-effective and timely interventions. This model is more successful than plan-based care management programs that rely mostly on telephone contact with members with as low as an 8% engagement rate.

Finally, the sustainability will be ensured with more flexible and less burdensome reimbursement mechanisms that evolve towards bundled payments around episodes of care and away from fee-for-service billing for individually authorized services from the MCO. The flexibility in these arrangements will allows the behavioral health providers to allocate staff according to EE need as opposed to which provider and service are reimbursable. For example, 30 minutes of individual therapy is commonly billed in an outpatient clinic, but weekly peer support contacts and monthly check-ins with a clinician may be better suited to the EE's needs.
Through alternative payment mechanisms the ACO will also promote sustainability with alignments towards shared savings and eventually, shared risk. These contractual agreements will reduce administrative overhead and maintain a focus on reducing total cost of care for increasing numbers of the BH CP and larger ACO population.

Community Partner Program Budget Report

		Clinical and Support Options					
Program Revenue	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
Estimated Enrollees- Start of Period (All Enrollees)		0	1,200	2,100	2,100	2,100	
Estimated Enrollees - End of Period (All Enrollees)		1,200	2,100	2,120	2,125	2,125	
Estimated Enrollees - Monthly Average (excl CBFS enrollees)		800	1,650	2,100	2,100	2,100	
Estimated Enrollees - Monthly Average (CBFS enrollees only)		10	25	25	25	25	
Estimated Program Revenue (excl CBFS enrollees)		$ 1,008,000	$ 3,564,000	$ 4,536,000	$ 4,536,000	$ 4,536,000	$ 18,180,000
Estimated Program Revenue (CBFS enrollees only)		$ 17,500	$ 75,000	$ 75,000	$ 75,000	$ 75,000	$ 317,500
Total Estimated Program Revenue		**$ 1,025,500**	**$ 3,639,000**	**$ 4,611,000**	**$ 4,611,000**	**$ 4,611,000**	**$ 18,497,500**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -	$ -	$ -	$ -
Revenue for Operations		**$ 1,025,500**	**$ 3,639,000**	**$ 4,611,000**	**$ 4,611,000**	**$ 4,611,000**	**$ 18,497,500**

Program Expenses		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Salary		$ 176,396	$ 1,048,489	$ 2,617,958	$ 3,002,746	$ 3,092,829	$ 3,185,613	$ 13,124,031
Fringe		$ 40,571	$ 241,152	$ 602,130	$ 690,632	$ 711,351	$ 732,691	$ 3,018,527
Total Personnel Costs		$ 216,967	$ 1,289,641	$ 3,220,088	$ 3,693,378	$ 3,804,180	$ 3,918,304	$ 16,142,558
Training & Professional Development		$ -						$ -
Travel		$ -	$ 76,658	$ 162,250	$ 192,720	$ 204,682	$ 210,822	$ 847,132
Equipment			$ 18,317	$ 27,500	$ 22,560	$ 28,087	$ 28,630	$ 125,094
Supplies		$ -	$ 13,851	$ 29,120	$ 30,912	$ 31,839	$ 32,795	$ 138,517
Contract Services (consulting, professional)		$ -	$ 30,168	$ 48,051	$ 62,991	$ 64,881	$ 66,827	$ 272,918
Software licensing			$ -	$ -	$ -	$ -	$ -	$ -
Telecommunications			$ -	$ -	$ -	$ -	$ -	$ -
Occupancy (rent, utilities, maintenance)		$ -	$ 91,606	$ 190,095	$ 193,897	$ 199,714	$ 205,705	$ 881,017
Other		$ -	$ 23,701	$ 43,564	$ 43,564	$ 44,872	$ 46,218	$ 201,919
Total Direct Costs		$ 216,967	$ 1,543,942	$ 3,720,668	$ 4,240,022	$ 4,378,255	$ 4,509,301	$ 18,609,155
Indirect Cost/Administrative Overhead	**11.6%**	**$ 25,168**	**$ 179,097**	**$ 431,597**	**$ 491,843**	**$ 507,878**	**$ 523,079**	$ 2,158,662
TOTAL EXPENSES		$ 242,135	$ 1,723,039	$ 4,152,265	$ 4,731,865	$ 4,886,133	$ 5,032,380	$ 20,767,817
Surplus/Shortfall		*$ (242,135)*	*$ (697,539)*	*$ (513,265)*	*$ (120,865)*	*$ (275,133)*	*$ (421,380)*	*$ (2,270,317)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
CP Director	$ 83,000.00	0.75	3	$ 15,563
CP Director	$ 83,000.00	1	4	$ 27,667
Nurse Manager	$ 75,000.00	1	3	$ 18,750
Care Manager Supervisor	$ 55,000.00	1	3	$ 13,750
Clinical Care Manager	$ 40,000.00	4	2	$ 26,667
Care Coordinator Supervisor	$ 50,000.00	2	3	$ 25,000
Care Coordinator	$ 33,000.00	6	2	$ 33,000
Peer Coach	33000	2	2	$ 11,000
Administrative Assistant	30000	1	2	$ 5,000
Total Salary (Program Budget Line 1)		**18.75**		**$ 176,395.83**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe	Fringe
Fringe Item	$ 176,395.83	23%	$ 40,571
Total Fringe (Program Budget Line 2)			**$ 40,571**

Total Personnel*	**$ 216,967**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

1. The CP Director has overall responsibility for the direct operation of the program; during the preliminary period, she will be engaged in recruitment, establishing relationships with ACOs and other parties, establishing workflows and procedures, learning/advising about the EHR use, etc. The CP Director will start 0.75 time in the program on 11/1/17 and will go to full-time on 2/1/18. *A significant role for the director and all staff during this period will be team-building.*
2. Nurse Manager during PBP will assist in establishing workflows and procedures, recruiting additional staff, learning/advising about the EHR use.
3. Care Manager Supervisor during PBP will be responsible for recruitment of Clinical Care Managers, learning/advising about the EHR use, orienting new staff.
4. Clinical Care Managers during the PBP will receive orientation to all aspects of the program and will begin to review and manage referrals as they arrive from Mass Health/ACOs.
5. Care Coordinator Supervisors during the PBP will recruit Care Coordinators and Peer Coaches, become oriented to the EHR and all apects of the program, orient new staff.
6. Care Coordinators during PBP will receive orientation to all aspects of the program and will begin to connect with other providers, review referrals as they arrive from Mass Health/ACOs.
7. Peer Coaches during PBP will receive orientation to all aspects of the program and will begin to connect with other providers and peer organizations, review referrals as they arrive from Mass Health/ACOs.
8. Administrative Assistant will provide administrative support to the team during the PBP.

JSK - Medical Director time indicated on Staffing model but not included here --that is because we would not charge the program for the medical director during the PBP.

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Total Training and Professional Development (Program Budget Line 3)			

Provide a description of each Training and Professional Development line item included in the table above:

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
			Total Mileage	

Travel Expense Description	Cost
Total Mileage	$ -
Parking and tolls	
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ -**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

Row 5 - Equipment

Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost

Total Equipment (Program Budget Line 5)				

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Total Supplies (Program Budget Line 6)			

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost

Total Software Licensing (Program Budget Line 8)		

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Total Telecommunications (Program Budget Line 9)			

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent			$ -
Utilities			$ -
Repair and Maintenance			$ -
			$ -
			$ -
Total Occupancy (Program Budget Line 10)			

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

Row 11 - Other

Other Direct Expense Description	Cost

Total Other (Program Budget Line 11)	

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	**11.60%**	**$ 27,130.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

CSO's federally approved indirect cost rate is 11.6%. This rate covers the cost for all indirect expenses (executive management, finance, liability insurance, organizational infrastructure and the like) for CSO programs.

Community Partner Infrastructure Budget Report

		Clinical & Support Options					
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
PMPM Infrastructure Rate		$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
Engaged Enrollees		1,200	1,200	2,100	2,120	2,125	
Estimated Infrastructure Funds		$ 840,000	$ 1,239,107	$ 1,297,590	$ 1,155,061	$ 1,001,584	**$ 5,533,343**
At- Risk Withhold Rate			25%	44%	63%	81%	
Withhold			$ 306,007	$ 566,120	$ 722,622	$ 816,232	**$ 2,410,981**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 840,000	$ 933,100	$ 731,470	$ 432,440	$ 185,352	**$ 3,572,362**

Infrastructure Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology								
IT Staffing including Fringe		$ 55,248	$ 70,725	$ 72,847	$ 75,032	$ 77,283	$ 79,600	**$ 430,735**
Development Adaptation of EHR and/or Care Management System		$ 62,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	**$ 112,000**
Technology for Service Delivery		$ 6,000	$ 48,000	$ 37,800	$ 42,950	$ 4,500	$ 4,500	**$ 143,750**
Other Technology Expenses		$ -	$ 17,675	$ 30,300	$ 31,815	$ 31,815	$ 33,362	**$ 144,967**
Total Technology		$ 123,248	$ 146,400	$ 150,947	$ 159,797	$ 123,598	$ 127,462	**$ 831,452**
Workforce Development								
Workforce Development staffing including Fringe		$ 4,230	$ 34,686	$ -	$ -	$ -	$ -	**$ 38,916**
Recruitment Expenses		$ 24,700	$ 15,000	$ 5,000	$ 5,000	$ 5,000	$ 2,500	**$ 57,200**
Training Expenses		$ -	$ 5,000	$ 10,000	$ 6,300	$ 5,000	$ 5,000	**$ 31,300**
Retention Expenses		$ -	$ -				$ 4,000	**$ 4,000**
Total Workforce Development		$ 28,930	$ 54,686	$ 15,000	$ 11,300	$ 10,000	$ 11,500	**$ 131,416**
Business Start Up Costs								
Office Equipment (PBP & BP1 only)		$ -	$ 72,625.00					**$ 72,625**
Office Furniture (PBP & BP1 only)		$ -	$ 53,610.00					**$ 53,610**
Ramp-up Costs (PBP BP1, BP2 and BP3 only)		$ 242,135	$ 697,539	$ 513,265	$ 120,865			**$ 1,573,804**
Total Business Start Up Costs		$ 242,135	$ 823,774	$ 513,265	$ 120,865			**$ 1,700,039**
Operational Infrastructure								
Operation Staffing including Fringe		$ 34,081		$ -	$ -	$ -	$ -	**$ 34,081**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Total Operational Infrastructure		$ 34,081	$ -	$ -	$ -	$ -	$ -	**$ 34,081**
Indirect Cost/Administrative Overhead Rate	11.6%	$ 21,606	$ 37,969	$ 19,250	$ 19,847	$ 15,497	$ 16,120	**$ 130,289**
TOTAL INVESTMENTS		**$ 450,000**	**$ 1,062,830**	**$ 698,462**	**$ 311,809**	**$ 149,095**	**$ 155,082**	**$ 2,827,278**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
IT Manager	$ 60,000.00	0.2	7	$ 7,000
Business systems analyst	$ 65,000.00	0.5	7	$ 18,958
Business systems manager	$ 65,000.00	0.5	7	$ 18,958
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary			$ 44,917
	Fringe rate	23.0%	Total Fringe	$ 10,331
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 55,248**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's con

1. IT Manager is responsible for the overall implementation of EHR upgrades and integration of all software products used.
2. Analyst manages implementation of connectivity to the Mass HIway; develops and implements a workflow to transmit eligibility files to our Care Coordi and user experience of the care coordination application; develops and implements a data collection system in the EHR for CP related services; designs, im
3. The clinical manager devoted to this team works closely with the analyst and clinical managers to design, on CSO's very flexible EHR, the actual docume discrete from CSO's treatment record. Business systems clinical manager

JSK - The Business Systems Clinical Manager should be migrated to the operational Staffing including Fringe Row 12. This is an existing position that is a Operations staffing pattern; it is not specific to CP operations, though will have significant time allocated to CP during the PBP. Correct title is Business error in the previous submission).

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Purchase of eLabs software module for Credible	$27,000

	A	B	C	D	E	F	G
34	Purchase FHIR HL-7 system upgrade	$ 35,000.00					
35							
36							
37							
38							
39	**Total Development and Adaptation of EHR and Care**						
40	**Management System**	$62,000					
41	**(Infrastructure Budget Line 2)**						
42							
43	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
44	***contract and how the costs were determined:***						
45							
46	1. Case management functionality will be developed on Credible EHR by in-house IT/Business Systems staff. We must purchase an						
47	additional module to support capacity to accept, store and share lab reports electronically						
48	2. Fast Healthcare Interoperability Resources software is needed for Mass HIway (and any other HIE) connectivity.						
49	CSO is in the final stages of its process with Credible to get securely connected to the Mass HIway.						
50							
51							
52							
53							
54							
55							
56							
57							
58	**Row 3 - Technology for Service Delivery**						
59	**Description of Expense**	**Cost**					
60	New switches at two sites	$ 4,000.00					
61	Additional wifi licenses at two sites	$ 2,000.00					
62							
63							
64							
65							
66	**Total Technology for Service Delivery**	$ 6,000.00					

	A	B	C	D	E	F	G
67	**(Infrastructure Budget Line 3)**	$ 6,000.00					

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

1. PoE switches are required for adding new devices (e.g. computers, phones) at each site.
2. We must add licenses for each wifi devise added to our network.

Row 4 - Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses (Infrastructure Budget Line 4)	

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Human Resources Administrative Coordinator	$ 33,000.00	0.25	5	$ 3,439
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0.25		$ 3,439
	Fringe rate	23.0%	Total Fringe	$ 791
			Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)	**$ 4,230**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

HR Administrative Coordinator is the key HR staff member for "onboarding" new hires for the CP program.

Row 6 - Recruitment Expenses

Description of Expense	Cost
Monthly fee for Indeed postings - CP positions (Nov - Dec) @ $3,100 per month	$ 6,200.00
Monthly fee for Indeed postings plus sponsored positions premium visibility - CP positions (Jan - May) @ $3,700 per month	$ 18,500.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 24,700.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

CP manager and clinical positions, which we are anticipating will be challenging to recruit, will be allocated premium positions on Indeed, at additional cost. (Indeed has a monthly charge for premium placement of ads online. This budget will allow us to get premium placements for hard-to-recruit positions in this very competitive environment.

Row 7 - Training Expenses

Description of Expense	Cost
Most CSO training expenses are included in our	
indirect costs, which is why they are not shown here	
Total Training Expenses (Infrastructure Budget Line 7)	

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Row 8 - Retention Expenses

Description of Expense	Cost
Total Retention Expenses (Infrastructure Budget Line 8)	

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Business Start Up Costs - Prep Budget Period

Row 9 - Office Equipment

Description of Expense	Cost

	A	B	C	D	E	F	G
228							
229							
230							
231							
232							
233	**Total Office Equipment**						
234	**(Infrastructure Budget Line 9)**						
235							
236	***Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were***						
237	***determined:***						
238							
239							
240							
241							
242							
243							
244							
245							
246							
247							
248							
249							
250							
251							
252	**Row 10 - Office Furniture**						
253	Description of Expense	Cost					
254							
255							
256							
257							
258							
259							
260	**Total Office Furniture**						

	A	B	C	D	E	F	G
261	**(Infrastructure Budget Line 10)**						
262							
263	***Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were***						
264	***determined:***						
265							
266							
267							
268							
269							
270							
271							
272							
273							
274							
275							
276							
277							
278							
279	**Community Partner <u>Infrastructure</u> Budget Report - Operational Infrastructure - Prep Budget Period**						
280	**Row 12 - Operational Staffing including Fringe**						
281	**Position**	**Annual Salary**	**FTEs**	**# Months**	**Total**		
282	AVP Community & Family Services	$ 100,000.00	0.35	5	$ 14,583.33		
283	VP Strategic Development	157,500.00	0.2	5	13,125.00		
284					$ -		
285					$ -		
286					$ -		
287					$ -		
288					$ -		
289					$ -		
290					$ -		
291		Total Salary	0.55		$ 27,708.33		

	A	B	C	D	E	F	G
292		Fringe rate	23.0%	Total Fringe	$ 6,372.92		
293	**Total Program Staffing including Fringe**				**$ 34,081.25**		
294	**(Infrastructure Budget Line 12)**						
295	***For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting***						
296	***the terms of the CP's contract:***						
297							
298	The Associate VP of Community & Family Services is responsible for the overall development and management of the CP program.						
299							
300	The VP of Strategic Development will provide executive and administrative leadership and support for all aspects of the						
301	implementation.						
302							
303							
304							
305							
306							
307	**Row 13 - Other Operational Expenses**						
308	Description of Expense	Cost					
309							
310							
311							
312							
313							
314							
315	**Total Other Operational Expenses**						
316	**(Infrastructure Budget Line 13)**						
317							
318	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms***						
319	***of the CP's contract and how the costs were determined:***						
320							
321							
322							
323							
324							

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**11.60%**	**$ 21,606.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

CSO's federally approved indirect cost rate is 11.6%. This rate covers the cost for all indirect expenses (executive management, finance, liability insurance, organizational infrastructure and the like) for CSO programs.

4. PBP Infrastructure Budget Narrative

	A	B	C	D	E	F	G
355							
356							
357							
358							
359							
360							
361							
362							

Community Partner Infrastructure Allocation Worksheet

	Insert Contractor Name Here						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 840,000	$ 933,100	$ 731,470	$ 432,440	$ 185,352	$ 3,572,362
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL INVESTMENTS	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Development and Adaptation of E.H.R/Care Management System	Contract for and operationalize "Credible Connect" to connect E HR to Mass HIway	11/01/17	05/31/18	Connection established and tested	JSK - PLEASE UPDATE			Information exchanged via Hiway with at least one external organization	JSK - PLEASE UPDATE		
Technology												
Technology												
Technology												
Workforce Development	Training Expenses	(NOTE: Training expenses are included in Indirect; we still have training goals) Train new staff on integrated care delivery and care coordination	03/01/18	05/31/18	Management team has completed training	JSK - PLEASE UPDATE			All staff hired as of 5/1/18 have been trained by 5/31/18	JSK - PLEASE UPDATE		
Workforce Development												
Workforce Development												
Workforce Development												
Business Start Up Costs	Program Staffing including Fringe	Recruit management team	11/01/17	05/31/18	Core senior managers recruited and on board	JSK - PLEASE UPDATE			Fully operational program management team recruited	JSK - PLEASE UPDATE		
Business Start Up Costs												
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Operation Staffing including Fringe	Design/develop/test Credible E HR workflows	11/01/17	03/31/18	AVP, CP Director & Business Systems team complete design of workflows and test to find them functional	JSK - PLEASE UPDATE			Newly hired staff have been trained and are competent in using E HR	JSK - PLEASE UPDATE		
Operational Infrastructure												
Operational Infrastructure												
Operational Infrastructure												

BH Community Partner - Staffing Model

Clinical and Support Options

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	1200	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	1	*Total management oversight of BH CP*
3	Medical Director	0.1	*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs	5	
5	Clinical Care Managers (RN)		*Do not include FTEs listed in line 4*
6	Clinical Care Managers (LPHA)	10	*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders	4	*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff		*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	27	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)	8	*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists		
12	Administrative Support		
13			
14			
	Total FTE	55.1	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1:240	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	1:9	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff: There are three Supervisor positions for care coordinators. In addition, care coordinators will work in teams with clinical care managers, who will be able to advise and coach the care coordinators. We may also designate Senior Care Coordinators at some sites, to provide case consultation and coaching for their peers. We anticipate having significant clinical staff resources to mentor and coach our Care Coordinators.

SECTION 7.3 INITIAL DSRIP PARTICIPATION PLAN

7.3.A. EXECUTIVE SUMMARY

Goals*: CSO's service goal* as a CP will be to effect greater collaboration and coordination across the spectrum of healthcare providers--inpatient medical and BH, primary and specialty medical, outpatient and community-based BH, residential, LTSS and emergency care. We share Mass Health's expectation that this effort will achieve the triple aim—improving health status, providing quality care, and reducing the total cost of care—and we are aligned with this purpose. *CSO's operational goal* is to implement this program efficiently, expeditiously, and sustainably. We will approach operations with a clear plan and model set forth for the entire implementation team, with the flexibility and agility to adapt our plans and process in response to changing conditions, consumer feedback, and feedback from ACOs, MCOs and Mass Health.

Service areas: CSO proposes to act as a BH CP in five service areas: Northampton, Greenfield, Pittsfield, and North Adams (in western Mass) and Athol (in central Mass). CSO currently provides treatment and support services for BH clients in all of these areas.

Number of enrollees to be supported: Based on Mass Health's projections of targeted members in these service areas, we expect to be assigned approximately 3,200 members who live in the service areas for which CSO is applying. Based on the number of Mass Health members CSO currently serves, we expect that a high percentage of the assigned members will be individuals already familiar to CSO, which will ease the engagement process and leads us to estimate a 60% engagement rate.

Challenges: These geographic areas are comprised of small, generally under-resourced cities and rural towns. There are many challenges to providing care in this environment, including these three key issues:

- a shortage of primary care providers--the ratio of residents to PCPs in Franklin County is 51% higher than for the state as a whole;
- small private primary care practices, unaffiliated with a hospital system or ACO, with the result that BH providers have many more practices with whom they must maintain relationships;
- public transportation is very limited, leaving low income households isolated and/or facing significant barriers to accessing care and support services.

In CSO's 60+ years of working in these communities, we have developed a service culture with high levels of community outreach and home-based services to accommodate isolated clients. We have an intensely relational style of collaborating, working with dozens of independently practicing healthcare providers, as well as more sizeable groups like Baystate Health and Valley Medical Group. We have a long history of working closely with a broad range of community-based organizations—it is the only way to function effectively in this small city/rural culture.

Operational plan: We will be able to accept 3,200 assignments in the first eleven months of the program (year one plus two months of year two) by accepting 300 assignments per month from Mass Health, while providing ongoing services to the members who actively engage. By the end of year one, we expect to have approximately 1900 actively enrolled and we project to reach scale of 2,000-2,200 enrolled members (including both assigned and referred Members) in year two.

We project to sustain this level of service for the duration of the five-year period. While CSO could develop greater capacity, we believe this volume is a proportionate share of Mass Health's total capacity for BH CP slots for these service areas.

CSO is in the advantageous position of having a fully operational, optimally flexible EHR in place. Working with the vendor, Credible, our IT and Business Systems team will be working through the rest of 2017 to refine the care management capacity of the system. Every player in the re-designed Mass Health system—ACOs, MCOs, CPs and providers—will be challenged by incompatible record systems and the need to move clinical and utilization from one entity to another in a timely, accurate and secure manner. We are confident that we are in a better-than-most position to both import and export information with Credible.

CSO has an able and experienced executive team to manage the implementation of this program; each member has a focused plan for this important endeavor. The VP overseeing the CP will be Sandi Walters, LICSW, who brings over ten years' experience managing MH and SUD programs, along with demonstrated skills at collaboration. She will be assisted by Deborah Ekstrom, who has nearly 40 years of experience in the field, including eight years of managing integrated primary care and BH service delivery, as well as public sector care management.

Staff recruitment is always a challenge in this market. CSO's plan includes a significant investment of DSRIP infrastructure funds on aggressive recruitment efforts throughout the duration of the project. A recent revision of our recruitment strategy has increased our candidate pool four-fold and resulted in high quality new hires. We will continue (and continually revise) this strategy to sustain the workforce needed for the CP program. We project to open the program with 4 RN's, 4 Clinical Care Managers, 12 Care Coordinators and 6.5 Peers and will get to scale in year two with 5.5 RN's, 12 Clinical Care Managers, 35 Care Coordinators and at least 8 Peers.

As indicated in our DSRIP budget, infrastructure investments will be most substantial in the prep phase (exceeding the resources available) and year one, tapering slightly in year two. By year three, we expect our ongoing infrastructure investment to level out to a maintenance level.

7.3.B. SUPPORTING POPULATIONS AND COMMUNITY ENGAGEMENT

1. As a leader in the community mental health movement, CSO has a long history of community partnership and collaboration, which is deeply embedded in our agency culture. CSO maintains both region-wide and area-specific relationships that serve to enhance support for our focus population. In addition to the rich array of services and supports we offer directly, **CSO maintains the following collaborations that spread across all service areas (Northampton, Greenfield, Athol, Pittsfield, North Adams):**

Department of Mental Health	Providers meeting to collaborate and coordinate care; Clubhouse and Respite regular quarterly meetings; collaboration on referrals and DMH case management
Department of Public Health - BSAS	core provider for BSAS; regular meeting with BSAS staff to collaborate and coordinate care; ensure access to service delivery throughout region
Department of Transitional Assistance	collaboration around benefit application for consumers; cross-referral to CSP programs
Massachusetts Rehabilitation Commission	core provider of MassRehab evaluation and employment services; collaboration and referral relationship
NAMI	consumer support groups; resource library; advocacy activities
Veterans Administration (VA)	outreach and HUD housing support; coordination of care for veterans
Western Mass Network to End Homelessness	CSO is on leadership committee; coalition of homeless service agencies across 4 western Mass counties
Providence Hospital	SUD treatment; Inpatient psych; coordination of care and disposition planning
Brattleboro Retreat	Inpatient and stepdown SUD treatment; coordination of care and disposition planning
Behavioral Health Network	Material subcontractor BHCP; Care Coordinaton; Substance Abuse Provider

Area-specific collaborations that will enhance BH CP service delivery system include:

In Northampton area:

Cooley-Dickinson Hospital	ESP service collaboration; CSO provides medical/surgical patients w/ BH evaluation and care coordination; disposition planning; step-down and inpatient referrals and collaboration on transitional services; CARES collaborations
PCP Practices: Valley Medical Group, Baystate, Cooley Dickinson	coordination and collaboration re: primary and specialty medical care; cross referrals
ServiceNet	Transitional housing program; CBFS; Home Care services
Hampshire County House of Corrections	provide care transitions for people released; SUD recovery coaching, CARES & CSP support; monthly meeting to address continuum of care opportunities & coordination of referrals/reintegration process for persons with BH needs
Council of Social Agencies	Hampshire county service provider network; coordinate and collaborate on community services; address service gaps; provide information regarding new services and resources
Gandara Center	SUD programming, including residential SUD services
Amherst Homeless coalition	community planning to address homeless and housing needs
Community Action	entitlement enrollment; community programming
Tapestry Health	Training; health education; overdose prevention

In Greenfield area:

Baystate Franklin Medical Center	ESP service collaboration; disposition planning; step-down and inpatient referrals and collaboration on transitional services; CHART care coordination collaborator/subcontractor; ED navigation; CARES peer support collaboration
Primary Care Practices of Valley Medical Group & Baystate Health	coordination and collaboration re: primary and specialty medical care; cross referrals
Behavioral Health Network	Detox/TSS/CSS provider; collaborator and subcontractor
Franklin County Community Health Center	Coordination and collaboration re: primary care; cross referrals; health insurance enrollment; MOU for primary referral relationship; health

	screenings provided on site at CSO
ServiceNet	Transitional housing program; CBFS; Home Care services
NELCWIT	Domestic violence support; referral and resource
Community Action	Communities that Care Coalition; entitlement support and enrollment; social services support
LifePath	LTSS provider; cross referrals; Adult protective services
Recovery Learning Center	Peer run groups; shared resources; cross referrals
Opioid Task Force	Collaboration re: SUD resources
YMCA	Wellness programming and collaboration
Seeds of Solidarity	Gardening and nutrition supports
Clean Slate	Provider of MAT; collaborate on treatment coordination/cross referral
Community Substance Abuse	Collaboration and cross referrals

In Athol area:

Athol Memorial Hospital/Heywood Health System	ESP provider; CHART grant collaborator; ED navigator; disposition planning; regular meeting to coordinate care and collaborate on services; planned co-location in new medical arts building in 2018
Franklin County Community Health Center – Orange	Coordination and collaboration re: primary care; cross referrals; health insurance enrollment; MOU for primary referral relationship; health screenings provided on site at CSO
North Quabbin Physician's group	coordination and collaboration re: primary & specialty care; cross referrals
North Quabbin Community Coalition	Community provider network to plan for gaps in services; development of resources; collaborate on care; subcontractor for CSA Systems of Care
LifePath	LTSS provider; cross referrals; Adult protective services
YMCA – Athol	Wellness programming and collaboration
NAMI	Host WM AMI meetings on site; collaborate with local chapter
Clean Slate	Provider of MAT; collaborate on treatment coordination/cross referral

In Pittsfield and North Adams areas:

Brien Center	ESP, SUD provider; detox referrals to CSO CSP; Inpatient services; CBFS
North Adams Regional Hospital	Outpatient and specialty services; collaboration and coordination of care
The Louison House	N Adams family shelter
Berkshire Medical Center	McGee Detox; CSS; Inpatient and medical care coordination & collaboration
NAMI Pittsfield	Advocacy; cross referrals, resource library
Construct/Project HOME	Homeless/shelter support
Community Health Programs of Berkshire County	coordination and collaboration re: primary and specialty medical care; cross referrals; entitlement and insurance enrollment
Experience Wellness Center	Collaboration and coordination of referrals
Right Choice	Suboxone and Vivitrol provider; collaboration of treatment resources
MA Committee for Public Counsel Services	Legal support and public advocacy
Berkshire Community Action Council (BCAC)	Public entitlement enrollment; social service supports; collaboration and coordination of services
Kindred at Home	LTSS provider; home health aides; coordination of services

2. For all service areas, CSO will work with other service providers, the consumer advisory board, and community stakeholders to identify areas to strengthen relationships and expand connections to the community. BH CP Supervisors will engage in community outreach activities and be charged with following through with linkages to needed resources. Further planned Collaborations are described in 7.3.C.7.

3. BH CP staff will participate in regular staff meetings, of which community resources and connections to stakeholders will be regularly reviewed and shared. Supervisors also hold the

responsibility of reviewing community needs and collaborators. Resource guides will be made available at each site, and web based search libraries will be encouraged as resources.

7.3.C. COMMUNITY PARTNER SUPPORTS AND ACTIVITIES

CSO's vision and principles reflect commitment to community based care. CSO has experience in building new program models, experience that will allow us to expand our services on a rock-solid foundation of experience, tradition, expertise and readiness. The CSO philosophy is to provide services in natural settings whenever possible. Policies and procedures to support in-home and community based services include the regular outposting of staff to community sites, financial support for mileage reimbursement and portion of auto insurance related to business use; and written personnel policy and procedures that include home/community based service delivery locations. The following programmatic policies, procedures and activities will be incorporated into the contractual provisions of any agreement with ACOs and MCOs.

1. OUTREACH AND ACTIVE ENGAGEMENT

During initial engagement of each participant, the Care Coordinator will collect demographic information, risk factors, and locator information. Care Coordinators will have a high level of skill in soliciting information needed to locate an individual regardless of whether the person is homeless or living in transitory or vulnerable conditions. In addition, training is provided related to negotiation and sophisticated seek-and-find strategies for locating a difficult-to-reach individual to provide community based care and encouraging an individual to return for other clinic-based care.

Building on this initial engagement, Care Coordinators will foster continuous communication with participants by phone, email, text, and regular face-to-face contact to provide one-to-one support, remind participants of upcoming medical and behavioral health appointments, and make transportation arrangements. Because of the large number of individuals already served by CSO, we expect many of those referred for CP services to already be engaged with a CSO staff person. In those cases, a warm-referral introduction will be made by the primary staff at CSO to the Care Coordinator to ensure collaborative care and not duplication of effort.

Outreach to referred Enrollees will be aimed at contacting and helping Assigned Enrollees learn about CSO and the BH CP program. In order to achieve this aim, CSO will develop, implement, maintain, and adhere to a protocol for Outreach and Active Engagement of Assigned Enrollees, to be submitted to and approved by EOHHS.

We will contact the Enrollee within 30 days of ACO referral, arrange for a face-to-face meeting and will conduct a home visit or visit at a community venue (depending on Enrollee's preference) in order to actively engage the Enrollee. All activities conducted in relation to CP Care Coordination will entail a "warm handoff" in person by CSO staff to one another and to other providers and consultants involved in assessment, treatment planning, care coordination and service delivery.

CSO has specific expertise engaging with hard to reach individuals, including homeless members and individuals with SUD. Extensive training in EBP's such as Motivational Interviewing (MI) and Strength Based Case Management (SBCM) will be utilized to support staff in reaching and engaging such members. Creative approaches such as street based outreach, technology enhanced supports, and wraparound principles of persistence, trauma informed care, and empowerment will be utilized to ensure positive engagement.

Orientation: The CSO Care Coordinator will provide written information on the CSO program and how it works and will provide direct contact information. At this point, the Care Coordinator

will give the individual a clear and direct choice to opt out of the CSO program of supports as well as seek assignment of another provider. If the Enrollee opts to continue, he/she:

- Will be given a Consent for Participation form to sign, with an explanation from the Care Coordinator about what participation entails;
- Will be informed as to how CSO might use Protected Health Information and be given authorization forms to sign; and
- Will be signed up for Text4 Recovery (see Section 7.3.D) and will be educated on and signed up for the CSO Credible Patient Portal. Staff will train the member on access and use of the Portal.

Accessibility: CSO will provide care coordination and coaching services during times that ensure accessibility and meet the needs of the Enrollee to be served, including nights and weekend hours and at locations that ensure accessibility and meet the needs of the consumer population to be served. To the extent possible within the state Medicaid program CSO may provide transportation or transportation vouchers for Enrollees and will utilize mobile in-home, telehealth/telemedicine, and on-line connections to ensure that Enrollees have access to all services.

Retention and engagement in treatment is particularly difficult when participants experience co-occurring SUDs/SMI and other co-morbid conditions. To address this challenge, CSO employs a multidisciplinary approach, identifying participants at high-risk for relapse, maintaining close and continuous contact with participants, mitigating risks for drop out through effective transitional care, and engaging family members and other social supports as allies all part of our retention strategy. However, long-term engagement in care is built on the success of the initial identification and engagement process.

Thorough assessment and planning procedures as well as Care Team meetings will help identify individuals at high-risk for dropout and implement appropriate interventions in a timely manner. The MI approach to all Enrollee interactions focuses on building motivation to stay in treatment and the availability of integrated, accessible primary care, psychiatric services, and treatment ensures timely access to essential services in a single location. Family team meetings, when consented to and appropriate, will help educate family about how to best support their loved one in remaining in care and help them get the support and care they need.

2. Comprehensive Assessment and Person-Centered Treatment Planning

Comprehensive Assessment Process

Attachment: CSO Comprehensive Assessment is attached at the end of 7.3.C.

All new clients being referred for behavioral health care coordination will, at the time of first contact, receive a preliminary screening and risk assessment to determine acuity of needs. That screening may occur telephonically. The preliminary screening will be followed by: (1) an initial evaluation, and (2) a comprehensive person-centered treatment planning evaluation. Each evaluation builds upon what came before it. If the screening identifies an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent follow-up.

If the screening identifies an urgent need, clinical services are provided and the initial evaluation competed within one business day of the time the request is made. If the screening identifies routine needs, services will be provided and the initial evaluation completed within 10 business days. For those presenting with emergency or urgent needs, the initial evaluation may be conducted telephonically or by telehealth/telemedicine but an in-person evaluation is

preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved, the Enrollee will be seen in person at the next subsequent encounter and the initial evaluation reviewed. Enrollees will receive the comprehensive person-centered treatment planning evaluation to be completed within 90 calendar days of the first request for services.

CSO will refine a Comprehensive Assessment tool to be approved by EOHHS. The current CSO Comprehensive Assessment is attached, and will be updated as required in the implementation phase of BH CP planning. The elements of this tool will be reflected in domains set up in the Credible health record so the Credible's Care Plan functionality can be used to contain the goals of the Treatment Plan and to track it's progress. In addition, CSO will use standardized and validated screening and assessment tools and, where appropriate, brief motivational interviewing techniques. CSO uses culturally and linguistically appropriate screening tools, and tools/approaches that accommodate disabilities (e.g., hearing disability, cognitive limitations), when appropriate. If initial screening identifies unsafe substance use including problematic alcohol or other substance use, CSO conducts a brief intervention and the individual is provided or referred to Behavioral Health Network for a full assessment and treatment.

The Care Coordinator will assemble a Care Team, a group of individuals that work with the Engaged Enrollee to identify the Enrollee's status on the domains below and any other issues the Enrollee feels are important.

Each Care Team member will have a defined role appropriate to his or her licensure or training and relationship to the Engaged Enrollee. CSO will document the names and contact information of each member of the Care Team which will be immediately available to the Enrollee/LAR, the PCP and all members of the Care Team.

The assessment will address:

- Immediate care needs;
- Current services, including but not limited to any care coordination or management services and any services being provided by state agencies;
- Medical history, family medical history, and medical needs;
- Medications;
- Ability to communicate concerns, symptoms, or care goals;
- Functional status, including needs for assistance with any Activities of Daily Living (ADLs);
- Self-identified strengths, weaknesses, interests, care goals, wellness goals and personal goals;
- Current and past mental health and substance use including treatment history (e.g. medication assisted therapy, detoxification, residential treatment);
- Accessibility requirements, including but not limited to preferred language and specific communication needs, transportation needs, and equipment needs;
- Housing and home environment, including but not limited to risk of homelessness, housing preferences, and safety;
- Employment status, professional interests, and professional goals;
- Current use of and goals for leisure time;
- Legal status for individuals involved in the justice system;
- Education;

- Income and financial support;
- Available informal, caregiver, or social supports, including peer supports;
- Risk factors for abuse or neglect;
- Food security, nutrition, wellness, and exercise;
- Advance directives status and preferences and guardianship status;
- Current and relevant acute care plans for medical and behavioral health conditions; and
- Other domains and considerations identified by EOHHS as required elements.

The interdisciplinary Care Team is composed of individuals who work together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of Enrollees. The Care Team includes the Enrollee, the family/caregivers, the adult's family to the extent the Enrollee desires, and any other person the Enrollee chooses. All treatment planning and care coordination activities are person-centered and family-centered. The Care Team includes a Registered Nurse to review medical and medication history and a Clinical Care Manager (who will be a LICSW or LMHC) to give final review and approval of the Comprehensive Assessment. The Care Team as a whole will give a final review of the Assessment. The CSO Care Team will complete a Comprehensive Assessment within 3 months of the Enrollee's consent to participate in support services, which will be submitted for approval by the Enrollee's ACO PCP or designee, and the Enrollee/legally authorized representative (LAR) and state agency representatives that are involved in the individual's case management or care.

The comprehensive assessment is updated by the Care Team, in agreement with and endorsed by the Enrollee and in consultation with the primary care provider, when changes in the consumer's status, responses to treatment, or goal achievement have occurred.

Person-Centered Treatment Plan

Treatment planning is carried out by the Care Team including the Enrollee and desired caregivers and includes needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the Enrollee's words or ideas and, when appropriate, those of the family/caregiver. The treatment plan is comprehensive, addressing all services required, with provision for monitoring of progress towards goals. The treatment plan is built upon a shared decision-making approach. Where appropriate, consultation is sought during treatment planning about special emphasis problems, including for treatment planning purposes (e.g., trauma, eating disorders). The treatment plan documents the Enrollee's advance wishes related to treatment and crisis management and, if he/she does not wish to share their preferences, that decision is documented. The Care Plan will address the following components:

- Types, frequency, and duration of services needed by the Enrollee
- How services and care will be integrated and coordinated among the Enrollee's health care providers, Recovery Support Navigators and other community and social service providers;
- The individual's long and short-term goals, including wellness and social goals and specific barriers to achieve those goals;
- Crisis/Safety Plan that carefully considers risks to the individuals optimal health and well being and offers prevention/intervention strategies; and
- Any cultural or ethnic considerations and individual's preferences in type of support services or in how services are delivered.

Each element will be documented and entered into the Enrollee's health record in Credible where it can be made available through electronic information exchange. The Care Plan itself may be formatted as a video, written or recorded in a preferred language or presented in another digital format in addition to a written plan, according to the individual's need or preference. The Enrollee will be asked to formally approve the Plan in writing before it goes to the ACO's PCP for approval.

The Care Coordinator will share the Treatment Plan that has been approved by the Enrollee, CSO RN, CSO Clinical Care Manager and the Enrollee's PCP (or designee) with parties who need the Plan in connection with their treatment of the Enrollee, provision of coverage or benefits to the Enrollee, or related operational activities involving the Enrollee, including members of the Engaged Enrollee's Care Team, ACO, or MCO, and other providers who serve the Engaged Enrollee, including state agency or other case managers.

The Care Team will re-convene and review the individual's Care Plan every six months or more frequently if obstacles or barriers arise to prevent achievement of the Enrollee's stated goals or if there has been a change in the functional or heath status of the individual. The Care plan will be review in the event of a request by the Enrollee, family member, clinician, advocate, state agency case manager or informal caregiver.

All treatment planning and care coordination activities are person-centered and family-centered and aligned with the requirements of Section 2402(a) of the Affordable Care Act. All treatment planning and care coordination activities are subject to HIPAA (Pub. L No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws.

Once the Treatment Plan has been approved by the Enrollee or LAR, the Plan will be submitted to the PCP/ACO for approval.

Safety Planning: Our concept of safety planning is dynamic rather than the conventional—and static—"safety contract." Effective safety planning involves multiple staff, family members and collateral supports in which the all parties have a role in supporting and monitoring safety and mitigating risk. To address higher risk, we provide layers of support and oversight for our staff including collegial, supervisory, psychiatric and administrative. CSO staff share safety plans with appropriate collaterals and key stakeholders in the case. All staff have access to psychiatric consultation as a part of doing regular business as well as on an emergency basis, accessed through clinical supervisors and a 24/7 on call psychiatrist as part of the ESP team.

Duplication of effort/services: Where appropriate, CSO use an existing Comprehensive Assessment for an Enrollee rather than conducting a new Comprehensive Assessment, where the existing assessment has been conducted within three (3) calendar months prior to the individual's assignment. Likewise, existing Treatment Plans will be reviewed for responsiveness to the Comprehensive Assessment and for current relevancy for the Enrollee's status.

3. Care Coordination and Care Management

Care coordination services will assist individuals in sustaining recovery, and gaining access to needed medical, social, legal, educational, and other services and supports including meeting basic social needs. As part of its Wraparound philosophy, CSO coordinates care across the spectrum of health services, including access to behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. Care coordination activities are carried out in keeping with the

Enrollee preferences and needs for care and, to the extent possible and in accordance with the Enrollee's expressed preferences, with identified family/caregiver and other supports.

The responsibility of CSO care coordination is to be informed by community providers and resources, and to reach out and connect in meaningful ways with other sources of service and link with them, so that information is communicated appropriately, consistently, and without delay and patients needs are fully addressed. CSO will organize care activities on behalf of Engaged Enrollees to facilitate the appropriate delivery of health care services and improve health outcomes, including organizing care and facilitating communication across medical, behavioral health, LTSS, social, and pharmacy providers, agencies, and supports.

Care Coordinators, will "meet participants where they are at" both physically and emotionally, providing frequent, mobile, one-to-one support in a range of community and care settings, including motivational, relapse prevention, harm reduction counseling and crisis intervention measures to maintain participant contact and facilitate engagement or reengagement in any level of care that is of interest to participants to keep them connected to services, and maintain participant safety.

When participants are referred to other service providers, the Care Coordinator will determine whether it is appropriate to accompany participants to provide support, translation, and advocacy working one-to-one with participants to help them build their own capacity for self-management. (Of course, this will only be done if the Member wants this level of support.)

Peer coaches will be hired as care coordinators – and can be matched to clients based on best fit, appropriateness, services needed and the capacity of the peer to offer those. Peer services that will be available as appropriate include peer crisis support services, peer bridge services to assist individuals transitioning between residential or inpatient settings to the community, peer trauma support, peer support for older adults or youth, and peer-led wellness and skill development groups.

Communications: Each external agency who may provide services to the Enrollee identified by the Care Team as part of the Treatment Plan will be contacted by the CSO Care Coordinator to discuss the services needed by the Enrollee and to plan how best to make the warm hand-off from the Care Coordinator to service providers, including who at the direct care agencies will be the ongoing liaison to CSO's BH-CP. The duly approved Treatment Plan will be shared with parties who need the Plan in connection with their treatment of the Enrollee, provision of coverage/benefits to the Enrollee and the Care Coordinator will personally discuss their role in the Plan with them. The Plan will be shared also members of the Enrollee's Care Team, ACO, or MCO, and other providers who serve the Engaged Enrollee, including state agency or other case managers. Again, the Care Coordinator will be the designated liaison for ongoing contact about the Enrollee.

As described in Section 7.2.E and 7.3.D, CSO's system is able to interface with external providers, ACOs and MassHealth/TPA to provide and receive information electronically (in HIPAA and 42 CFR compliance) on an individual's Care Plan progress against its goals—service utilization, individual demographics, medical history, current medical status, problem lists, medication information, utilization of other service providers and community supports as well as documentation of these elements.

In terms of care management, CSO will develop a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to

meet an individual's and family's comprehensive health needs through communication and available resources to promote quality and improve health outcomes. Care will be managed among CSO, community support settings, labs, specialists and hospitals. High-intensity care management will provide supports for persons deemed at high risk of suicide, particularly during times of transitions such as from an ED or psychiatric hospitalization.

Our experience has shown us that, in order to be effective, Community Partner services must be assertive—continually reaching out to other care team members and providers for updates on their involvement with Members, to share information that CP staff has gathered and identified as important to share, to prompt other providers about reports or eligibility changes, etc. The CP role must be an active leadership role in order to be effective in system transformation. It is important to note that this leadership function is *facilitative,* not authoritarian.

4. CARE TRANSITIONS

The CSO Care Coordinator will ensure that he/she is notified if the Enrollee is hospitalized for any reason or if there is a major change in the individual's treatment setting (e.g. inpatient, partial hospitalization, crisis/respite, rehabilitation facility, residential treatment, SNF, etc.) CSO has, or will have agreements with hospitals, including emergency departments, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers. This includes procedures and services, such as peer bridgers, to help transition individuals from the ED or hospital. CSO will track when Enrollees are admitted to such facilities as well as when they are discharged.

CSO will work with ACO partners to set up notification systems between CP and ACO for all hospitalizations/discharge and follow-up. In the service areas where CSO is the ESP, we can track and notify any client hospitalized for psychiatric reasons. The CSO Business Systems team will work on an electronic notification exchange system that will include other facilities in addition to hospitals.

Comprehensive Transitional Care will be provided by the Care Coordinator with support from the Care Team, the Nurse, and the Clinical Care Manager to effectively support participants in mitigating crises, accessing appropriate levels of care, moving successfully between care environments and incorporation of strategies to reduce and prevent future hospitalization and Emergency Room utilization. Using ICM and medical interpretation, the Care Coordinator will ensure ongoing communication between hospital providers and Care Plan clinicians will provide on-site clinical services and consultations. The Care Plan will review all discharge summaries, conduct participant assessments, and develop a short-term transitional plan to address immediate needs related to housing, transportation, pharmacy, and family/other supports to assure participant will be capable of managing their care within their home environment. The Care Team will review and revise the PCTP, with emphasis on goals related to disease management and crisis prevention to reduce or prevent future hospitalizations, and will focus on increasing participant, and family caregiver skills through family support services, self-management strategies and Care Coordinator coaching and support.

CSO will make and document reasonable attempts to contact all Enrollees discharged from these settings within 24 hours of discharge. For anyone that may be a potential suicide risk, the care coordination agreement between these facilities and CSO includes a requirement to coordinate consent and follow-up services with the consumer within 24 hours of discharge, and continues until the individual is linked to services or assessed to be no longer at risk. The Care

Coordinator will conduct a face-to-face visit with the individual within 3 days of discharge from one of these settings and will initiate with the individual and his/her Care Team a review and update of the Treatment Plan.

5. MEDICATION RECONCILIATION

As part of care coordination, CSO make reasonable attempts to determine any medications prescribed by other providers for Enrollees and, upon appropriate consent to release of information, to provide such information to other providers if necessary. For each Enrollee who is discharged from an inpatient stay, CSO will conduct medication reconciliation within three (3) business days of the date of discharge. The CSO RN on the Care Team will conduct the medication reconciliation as follows:

- Contacting the Engaged Enrollee's PCP to verify that medication orders from discharge are appropriate;
- Verifying that medication orders are filled accurately;
- Ensuring that the Enrollee understands specific medication administration;
- Checking for any discrepancies and issues of medication non-compliance, particularly in cases of multiple prescribers;
- Supporting the Enrollee's adherence to medication regimen;
- Identifying supports that are available or could be made available to support the Enrollee in medication administration.
- For clients participating in a program with MAP, the nurse will collaborate with the MAP provider to ensure that communication between the prescribing physician and the MAP provider has been accurate and complete.

For enrollees discharged from an inpatient stay, CSO's CP team will arrange a nurse visit to the patient's home within 72 hours of discharge. If appropriate, a care coordinator will accompany the nurse to support engagement and prepare to provide follow up support. The nurse will have already reviewed discharge orders and have contacted the enrollee's PCP to have an accurate list of medication orders. S/he will reconcile the medications in the home with the orders. If there are any discrepancies, s/he will contact and review the situation with the prescriber and the pharmacy to resolve the discrepancy and either adjust the records (if, for example, 10 mg has been prescribed and 20 mg has been dispensed and patient has been re-instructed to take a half dose) or secure the appropriate medication.

The nurse will discuss each medication with the patient, to ascertain that the patient understands the purpose of each medication and the correct schedule and procedure for taking the medication (e.g., time of day, with or without food, etc.). If s/he determines that the patient will require further support to correctly take the medication, the nurse and care coordinator will make a plan for adherence to the medication regimen. Such support might come from the care coordinator, another staff member from the CP team, a household member, or another provider. The plan will be confirmed with any other involved party and documented. The plan will be entered in the enrollee's CP record and distributed to Care Team records. Other Care Team members may be consulted, as appropriate, about the plan for providing ongoing medication support.

6. HEALTH AND WELLNESS COACHING

Individuals with a diagnosis of mental illness not only suffer significant disparities of health status, especially for chronic health conditions, but also derive great physical and psychological benefits from a shift to healthier life habits. Health promotion is a key principle in our Wellness programming and is realized through comprehensive health education on the most common issues that act as barriers to our clientele's good health and well being. Sessions and activity groups are coordinated and scheduled at CSO and community sites and attendance will be encouraged and promoted for each Enrollee. CSO is currently utilizing the evidence based InShape model of health and wellness coaching, as described in 7.2.D.2., along with general health and wellness initiatives integrated into programming.

The CSO Wellness Initiative focuses on good nutrition, regular exercise, stress reduction techniques and symptom management support as components of a comprehensive wellness program. There is a focus on teaching members the behavioral skills to manage their chronic medical condition, and encourages reduction of high risk behaviors, establishment of linkage to accessible health promotion activities, and the integration of health and wellness goals into each members Person-Centered Treatment Plan. The CSO initiative provides a range of wellness activities (fitness, nutrition counseling and education, yoga, acupressure and smoking cessation supports). Wellness activities will include tobacco cessation groups, stress management, nutrition, goal setting, hiking and WRAP groups. Peer Mentors will be "exercise buddies" and trainers, perform outreach and follow up with other individuals and work with Enrollees on issues related to safe housing environments and stability within their community. In this way, wellness is fostered through trusted peer support relationships. CSO has an agency-wide smoke-free policy for all programs. Where meals and snacks are provided, they are highly nutritional; junk food is discouraged in all programs

Fitness: CSO operates a number of health and fitness programs in its Green River and Orange Clubhouses, on-site in the Greenfield outpatient center and has collaborative relationships with the Greenfield and Athol YMCAs. CSO has set up a system of YMCA membership that supports the use of facilities by up to 15 clients at a time with staff supervision. "Regular use" individuals can either opt to apply for their own YMCA membership and apply for the financial aid or can go to the YMCA with a peer support staff through the Wellness Program or with a peer support staff. Walking groups utilizing community trails are conducted at all of our site locations, including out of our Pittsfield, Greenfield, Northampton and Athol offices.

CSO Wellness Coordinators will conduct wellness and health coaching that is easily accessible and responsive to the Enrollee's Care Plan goals. This may entail fitness programming in the community at CSO's wellness facility, and/or enrolling in InSHAPE. The Enrollee will make choices among the available fitness options that are deemed to be most likely to lead to Plan goal fulfillment. The Wellness coach will link the Enrollee to community fitness programming which may include being mentored by a Peer Coach. The use of smart phone app's to track progress and provide motivational messaging will be encouraged and part of the training for individual's wishing to enhance their physical activity at any level. CSO Wellness Coordinators will work with our ACO partners to encourage fitness tracking incentives through the flexible dollar pool, such as distribution of Fitbits and pedometers to members.

Smoking Cessation: CP staff will use a Motivational Interviewing approach to discussing tobacco use with clients. As appropriate, they will be referred to smoking cessation programs, for evaluation by their PCP for medication-assisted cessation, to other support groups (e.g., NicA)

and/or to smoking cessation groups held by CSO at the clubhouses in Greenfield and Orange. It is important to recognize that, as with other substances, nicotine users are likely to move through various stages of change regarding their addiction. Our staff must differentially refer for care, depending on the client's readiness for change.

Health Education Sessions: These sessions run by the CSO Nurses will include topics like symptoms management, medication education and nutrition. Care Coordinators and Peer Coaches will offer groups to help members develop and enhance skills in money management, coping and stress management, interpersonal relationships, and self-advocacy.

All Health and wellness goals will be identified with the enrollee at onset of BH CP engagement, and goals updated with member guidance throughout the members participation. Health and Wellness goals will be integrated into the Person Centered Treatment Plan, and reviewed and updated as part of the regular Plan review. Progress on physical health indicators will be tracked and documented in Credible.

7. CONNECTION TO COMMUNITY AND SOCIAL SERVICES

CSO will develop and maintain collaborative relationships with community-based organizations in the five Service Areas in order to make referrals of Enrollees to the community support they need. We will maintain collaborative relationships with and have knowledge of the services and specialties offered by local providers, specifically BH and LTSS providers in the Service Areas; social and Flexible Services providers in the Service Area; and Primary Care Physicians and other specialists working with Enrollees.

Planned Collaborations: CSO has had a long-term partnership with the Department of Mental Health and has worked closely with the Department of Children and Families and Department of Public Health. These close relationships help ensure positive community-based outcomes for people who access services at more than one agency. We have experience in forming IAP treatment teams including stakeholders in agencies, community organizations and the individual's natural support systems and will continue this process as a Community Partner.

CSO maintains active linkages with other mental health, substance use, primary care, hospitals and ancillary services providers in all the targeted service areas. All of the collaborations described below and in 7.3.B will operate to support the Community Partner Program, along with Behavioral Health Network as our Material Subcontractor. CSO's experience in wraparound, person-centered programming, peer-to-peer support, community coalition building, and network development will contribute to a responsive and effective system of wraparound support.

CSO plans to connect Enrollees to social services and community resources by using its wraparound and warm handoff strategies. We have specific procedures for communication between levels of care, implementation of crisis plans and access to information across programs utilizing electronic medical records, voicemail, email and fax. Many of our community collaborators, too, have extensive experience in wraparound; we share a common perspective and underlying philosophy about service delivery. As part of wraparound, CSO actively moves individuals "up and down" service levels based on need. Not all Enrollees will need the same set of services in the same sequence.

CSO Care Coordinators, in collaboration with the Clinical Care Manager or the primary treatment provider, will screen all Enrollees for social service needs during initial engagement and Assessment, and may refer Enrollees to any of the entire range of external community-based programs. The Clinical Care Manager will utilize the "Assessed Needs Checklist" within the

MSDP Comprehensive Assessment to guide discovery and screening for social services and flexible supports needs of the Enrolled member. These range from job development and coaching to education to psychotherapy and medication services. In our service areas we are connected to a host of community options for ancillary or enabling services through referral: housing, legal services, child care, YMCAs, etc. CSO has a history of active linkage to wellness and support services including securing YMCA memberships, representation on housing boards, and the use of recovery groups. Our staff are skilled in assessing eligibility for other benefits: housing, child care vouchers, food stamps, fuel assistance, benefits eligibility, violence support programs, wellness programming, etc. In addition, individuals will have access to the array of CSO's programs.

Based on the individual's Treatment Plan, the Care Coordinator will identify community-based, social resources that will support the health and well being of each Enrollee. These may include:

- Services that support transitions from institutional settings into community settings;
- Home and Community-Based Waiver Services to divert individuals from institutional placements;
- Housing audit to maintain a safe and healthy home environment;
- Fitness and nutrition programs;
- Housing placement and supportive housing programs;
- Support programs for survivors of violence (crime, sexual assault domestic violence, etc)
- Flexible Services
- Other individual goods and services that address the Enrollee's needs and provide direct benefit and support specific outcomes related to the health and safety of the Enrollee in his or her home or community.

The Care Coordinator will provide information to each Enrollee on the available community-based, social and Flexible Services and assist each individual in accessing community-based and social services and resources as well as recommend Flexible Services to the Enrollee's ACO. We will ensure a continuing connection by monitoring and documentation of community service utilization in the Care Manager fields of the Credible electronic health record.

CSO will coordinate the provision of community supports with any other case management services an Engaged Enrollee receives to ensure that the CP activities supplement, but do not duplicate, other services provided. In particular, we will coordinate with each Enrollee's CBFS provider, if any, to inform the Enrollee's CBFS provider about the Enrollee's routine and specialty medical care including identifiable symptoms that may require routine monitoring and to develop the Enrollee's crisis plan to prevent use of emergency departments, hospitalizations and criminal justice involvement and coordinate activities for improving the Enrollee's health and wellness so that CBFS providers may reinforce the Enrollee's health and wellness goals

We will work closely with state agencies regarding services, care coordination, and agency case management as needed. This may include the Executive Office of Elder Affairs (EOEA), the Department of Children and Families (DCF), the Department of Mental Health (DMH), the Department of Developmental Services (DDS), the Department of Public Health (DPH), the Massachusetts Rehabilitation Commission (MRC), the Massachusetts Commission for the Deaf and Hard of Hearing, and the Massachusetts Commission for the Blind (MCB).

We will collaborate on individual service issues and treatment planning very closely with the *ServiceNet* CBFS Teams, whose members are "regular visitors" to the Respite program in Greenfield and Northampton, and with the *Brien Center* CBFS teams in Berkshire County. This will become an even more powerful collaboration as we deal collectively in a more structured way with the CBFS Teams. In addition, we have well established working relations with the key agencies in Franklin County and North Quabbin including the *ServiceNet* TAY program for young adults, *Life Path* (the former Franklin County Home Care) for elders, *ServiceNet* Emergency Shelter and Transitional Housing, *NAMI* for family members of individuals with SMI, *STAVROS* for individuals with physical disabilities (CSO has been formally recognized by STAVROS for having accessibility within our Franklin Respite Program), and the *Community Substance Abuse Clinic* and *Total Wellness Centers* providing recovery services for individuals with substance use, dependency or co-occurring disorders--all in addition to the collaboration with BHN as our Material Subcontractor.

We also have formal affiliations with Baystate Franklin Medical Center, Athol Memorial Hospital, Cooley Dickinson Hospital and Berkshire Medical Center. In Berkshire County, we have a close working relationship with the Brien Center for detox services, Emergency Services, and collaboration around CBFS clients. We are a member of the *"Collaborate This!"* collaborative in the Berkshires, which includes the Christian Center, Committee for Public Counsel Services, DMH, Advocacy for Access, the Brien Center, Smith College, AdLib and BCAC. We recently held a "Roadmap to Services" event at the Christian Center at which we coordinate services for potential clients, accept referrals, and conduct intakes on site.

CSO is a primary referral source with regular meetings for aftercare planning and step-down services with *Baystate Franklin Medical Center* Partial Hospital Program and has direct admission privileges with prearranged intake to that program. *Providence Hospital Inpatient facility:* CSO regularly receives referrals and attends discharge planning meetings about treatment and discharge plans for shared clients.

We have an Affiliation Agreement with *Western Mass Training Consortium's* Recovery Learning Center to provide peer specialist training and a client support network for ESP and Respite Services. *United ARC:* CSO provides CCS services to clients with developmental disabilities who are also mentally ill, in collaboration with the ARC. CSO frequently serves TAY clients in collaboration with *Dial-Self* in order to keep these youth out of homeless shelters.

To ensure BH CP staff are familiar with all available community resources that will benefit Enrolled members—including knowing community organizations and understanding the services they provide—CSO will (1) continually update our electronic resource directory; and (2) use supervisory and program meeting structures to continually share information. Care Coordinators will participate in regular staff meetings, at which community resources and connections to stakeholders will be regularly reviewed and shared. Supervisors also hold the responsibility of reviewing community needs and collaborators as part of their job descriptions. Resource guides will be available and web based search libraries will be encouraged as resources.

CSO staff are accustomed to thinking about clients' needs in a broad way, and not just limited to potential clinical interventions. We have experience working with DMH and DCF flex dollars and flexible supports and negotiating on behalf of clients needs to support transitions, client self-management and community tenure. We will seek to establish communication and administrative systems with each ACO that include appropriate controls, but minimal barriers, to appropriate and expeditious use of flexible funds and flexible supports for our Members.

ATTACHMENT: PROPOSED TOOL: MSDP COMPREHENSIVE ASSESSMENT

Adult Comprehensive Assessment

Person's Name (First MI Last):	Record #:	Date of Admission:
Organization/Program Name:	DOB:	Gender: ☐ Male ☐ Female ☐ Transgender

Presenting Concerns (In Person's /Family's Own Words)

Referral Source:
Reason for Referral:

What Occurred to Cause the Person to Seek Services Now (Note Precipitating Event, Symptoms, Behavioral and Functioning Needs):

Living Situation

What is the person's current living situation? (check one)
☐ Rent ☐ Own ☐ Friend's Home ☐ Relative's/Guardian's Home ☒ Foster Care Home ☐ Respite Care ☐ Jail/Prison
☐ Homeless living with friend ☐ Homeless in shelter/No residence ☐ Other:

☐ Residential Care/Treatment Facility: ☐ *Hospital* ☐ *Temporary Housing* ☐ *Residential Program* ☐ *Nursing/Rest Home* ☐ *Supportive Housing*

At Risk of Losing Current Housing ☐ Yes ☐ No Satisfied with Current Living Situation ☐ Yes ☐ No

Comments (Include environmental surroundings and neighborhood description):

Family History

Family History and Relationship, Parental/ Familial Caretaker Obligations:

Pertinent Family Medical, MH and SU History:

Developmental History and Status:

Social Support

Friendship/Social/Peer Support Relationships, Pets, Community Supports/Self Help Groups (AA, NA, SMART, NAMI, Peer Support, etc.):

Religion/Spirituality and Cultural/Ethnic Information:

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Adult Comprehensive Assessment

Person's Name (First MI Last):	Record #:

Legal Status and Legal Involvement History

Does Person Served have a Legal Guardian, Rep Payee or Conservatorship? ☐ No ☐ Yes; **If yes, complete and attach the Legal Status Addendum**

Is there a need for a Legal Guardian, Rep Payee or Conservatorship? ☐ No ☐ Yes / Explain:

Does the person have a history of, or current involvement with the legal system (i.e., legal charges)? ☐ No ☐ Yes; **If yes, complete and attach the Legal Involvement and History Addendum**

Education

Highest Level of Education Achieved: ☐ GED ☐ HS Grad ☐ College ☐ Vocational Training ☐ Graduate Degree Highest Grade Completed:

Person's Preferred Learning Style(s): ☐ Visual ☐ Auditory ☐ Verbal ☐Written ☐ Learn by doing
Currently Enrolled in Educational Program?: ☐ No ☐ Yes; **If yes, complete and attach Education Addendum**
Is person interested in further education or assistance in education?: ☐ No ☐ Yes: **If yes, complete and attach Education Addendum**

Employment and Meaningful Activities

Employment Status/Interests:

☐ Never Worked Currently Employed? ☐ No ☐ Yes; If yes, length of employment:
(If not currently employed) – Person served wants to work? ☐ No ☐ Yes ☐ Uncertain / Comments:
Does the person want help to find employment or vocational training? ☐ No ☐ Yes / Comments: **If yes, complete Employment Addendum**

Meaningful Activities (Community Involvement, Volunteer Activities, Leisure/Recreation, Other Interests):

Income/Financial Support

How does the person describe her/his current financial situation? ☐ Comfortable/ living within means
☐ Occasional struggle with finances ☐ Often struggles with finances ☐ Financial struggles are a major source of stress
Comments:

Do you receive any sources of financial assistance? ☐ SSI ☐ SSDI ☐ Food Stamps ☐ Contributions from family or friends
☐ Disability ☐ Child Support ☐ Veterans Benefits
☐ TAFDC ☐ EAEDC ☐Other:
If yes, Type and Amount:

Military Service

☐ **None Reported** - If None Reported, skip to the Substance Use / Addictive Behavior History Section

Military Status: ☐ Active ☐ Veteran	**Date of Discharge:** **Type of Discharge:** ☐ 1. Honorable ☐ 2. General (under Honorable Conditions ☐ 3. Other than Honorable ☐ 4. Bad Conduct ☐ 5. Dishonorable Reason:

Is a complete Military Service assessment needed? ☐ No ☐ Yes; **If yes, complete and attach Military Service Addendum**

Addictive Behavior and Substance Abuse History

Does person report a history of, or current, substance use or other addictive behavior concerns (i.e., alcohol, tobacco, gambling, food)? ☐ No ☐ Yes;. **If yes, complete and attach Addictive Behavior History/SA Addendum.**

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Adult Comprehensive Assessment

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Person's Name (First MI Last):	Record #:

Mental Health and Addiction Treatment History

Type of Service	Dates of Service	Reason	Name of Provider/ Agency:	Inpatient/ Outpatient	Completed
	/			☐ In ☐ Out	☐ No ☐ Yes
	/			☐ In ☐ Out	☐ No ☐ Yes
	/			☐ In ☐ Out	☐ No ☐ Yes
	/			☐ In ☐ Out	☐ No ☐ Yes
	/			☐ In ☐ Out	☐ No ☐ Yes
	/			☐ In ☐ Out	☐ No ☐ Yes
	/			☐ In ☐ Out	☐ No ☐ Yes

Efficacy of past and current treatment:

Psychiatric History (including past diagnoses):

Source(s) of Information: ☐ Person Served ☐ Significant other/Family member(s) ☐ Service Provider(s)
☐ Case Manager ☐ Written records ☐ Other:

Physical Health

PCP, Medical Specialist and Dentist Name, Credentials, Specialty	Telephone Number	Fax Number	Address	Date of Last Exam

Person's Name (First MI Last):	Record #:

Physical Health Summary

OR ☐ **Refer to Attached Physical Health Assessment**

Bureau of Substance Abuse Services (BSAS) Programs must complete the MSDP Infectious Disease Risk Addendum and the BSAS TB Assessment

Allergies: ☐ No Known Allergies ☐ **Yes, list below:**

Food: Medication Allergies and Medication Sensitivities (including OTC, herbal):
Environmental:

Physical Health Summary: (Include health history, chronic conditions, significant dental history, and current physical complaints that may interfere with the person's served functioning.)

Does the person use complimentary health approaches (e.g. natural products, mind-body practices, yoga)? ☐ Yes ☐ No
If yes, please describe:

Does the person wish to consider using complimentary health approaches and want help finding a provider? ☐ Yes ☐ No ☐ NA
If yes, please describe:

Sexual History/Concerns:

Pain Screening:
Does the person experience pain currently? ☐ Yes ☐ No Has the person experienced pain in past few months? ☐ Yes ☐ No
Describe the type, frequency, duration, intensity, identified cause, any limitations to functioning and what helps relieve the pain:

Nutritional Screening: (check all that are reported)
☐ Special diet? (e.g. diabetic, celiac) Follows special diet? ☐ Yes ☐ No ☐ Medications affecting nutritional status
☐ Weight gain/loss of 10 pounds or more without specific diet ☐ Change in appetite
☐ Binging ☐ Purging ☐ Use of laxatives ☐ Intense focus on weight, body size, calorie intake, exercise

Beliefs, perceptions, attitude, behaviors regarding food:

Physical Health Summary and Recommendations:
If person has not had physical exam in past year, or if person has reported pain without a determined cause, or if person has reported eating disordered behaviors that are not being medically followed:
☐ Referral for physical exam ☐ Referral for Nutritional Assessment
☐ Person declined exam (reason): ☐ PCP contacted

Medication Summary

Medication information and history of adverse reactions: (Include what medications work well and have worked well previously, any adverse side effects, why person doesn't take meds as prescribed and/or which one(s) the person would like to avoid taking in the future):

Is the person served currently taking any medication ☐ No ☐ Yes; If yes, complete and attach the Medication Addendum

Advanced Directive

Does the person have advanced directive established ☐No ☐Yes
If yes, what type? ☐ Living Will ☐ Power of Attorney ☐ Health Care Proxy ☐ Other:
If no, does the person wish to develop them at this time? ☐No ☐Yes / If yes, follow agency's procedure for completion

Trauma History

Does person report a history of trauma? ☐ No ☐ Yes
Does person report history/current family/significant other, household, and/or environmental violence, abuse or neglect or exploitation? ☐ No ☐ Yes
If the answer to either of the above questions is yes, complete and attach the Trauma History Addendum.

Revision Date: *1-30-17*

Adult Comprehensive Assessment

Person's Name (First MI Last):	**Record #:**

Mental Status Exam – (WNL = Within Normal Limits) (**) – *If Checked, Risk Assessment is Required*

Appearance/ Clothing:	☐ WNL	☐ Neat and appropriate	☐ Physically unkempt	☐ Disheveled	☐ Out of the Ordinary	
Eye Contact:	☐ WNL	☐ Avoidant	☐ Intense	☐ Intermittent		
Build:	☐ WNL	☐ Thin	☐ Overweight	☐ Short	☐ Tall	
Posture:	☐ WNL	☐ Slumped	☐ Rigid, Tense	☐ Atypical		
Body Movement:	☐ WNL	☐ Accelerated	☐ Slowed	☐ Peculiar	☐ Restless	☐ Agitated
Behavior:	☐ WNL	☐ Cooperative	☐ Uncooperative	☐ Overly Compliant	☐ Withdrawn	☐ Sleepy
	☐ Silly	☐ Avoidant/Guarded/ Suspicious	☐ Nervous/ Anxious	☐ Preoccupied	☐ Restless	☐ Demanding
	☐ Controlling	☐ Unable to perceive pleasure	☐ Provocative	☐ Hyperactive	☐ Impulsive	☐ Agitated
	☐ Angry	☐ Assaultive	☐ Aggressive	☐ Compulsive	☐ Relaxed	
Speech:	☐ WNL	☐ Mute	☐ Over-talkative	☐ Slowed	☐ Slurred	☐ Stammering
	☐ Rapid	☐ Pressured	☐ Loud	☐ Soft	☐ Clear	☐ Repetitive
Emotional State-Mood (in person's words):	☐ WNL	☐ Not feeling anything	☐ Irritated	☐ Happy	☐ Angry	☐ Hostile
	☐ Depressed, sad	☐ Anxious	☐ Afraid, Apprehensive			
Emotional State-Affect	☐ WNL	☐ Constricted	☐ Changeable	☐ Inappropriate	☐ Flat	
	☐ Full	☐ Blunted, unvarying				
Facial Expression	☐ WNL	☐ Anxiety, fear, apprehension	☐ Sadness, depression	☐ Anger, hostility, irritability		
	☐ Elated	☐ Expressionless	☐ Inappropriate	☐ Unvarying		
Perception:	☐ WNL					
Hallucinations-	☐ Tactile	☐ Auditory	☐ Visual	☐ Olfactory	☐ Command **	
Thought Content:	☐ WNL					
Delusions-	☐ None Reported	☐ Grandiose	☐ Persecutory	☐ Somatic	☐ Illogical	☐ Chaotic
	☐ Religious					
Other Content-	☐ Preoccupied	☐ Obsessional	☐ Guarded	☐ Phobic	☐ Suspicious	☐ Guilty
	☐ Thought broadcasting	☐ Thought insertion	☐ Ideas of reference			
Thought Process:	☐ WNL	☐ Incoherent	☐ Decreased thought flow	☐ Blocked	☐ Flight of ideas	
	☐ Loose	☐ Racing	☐ Chaotic	☐ Concrete	☐ Tangential	
Intellectual Functioning:	☐ WNL	☐ Lessened fund of common knowledge	☐ Impaired concentration	☐ Impaired calculation ability		
Intelligence Estimate -	☐ Develop. Disabled	☐ Borderline	☐ Average	☐ Above average	☐ No formal testing	
Orientation:	☐ WNL	**Disoriented to:**	☐ Time	☐ Place	☐ Person	
Memory:	☐ WNL	**Impaired:**	☐ Immediate recall	☐ Recent memory	☐ Remote memory	☐ Short Attention Span
Insight:	☐ WNL	☐ Difficulty acknowledging presence of psychological problems		☐ Mostly blames other for problems	☐ Thinks he/she has no problems	
Judgment:	☐ WNL	**Impaired Ability to Make Reasonable Decisions:**		☐ Mild	☐ Moderate	☐ Severe**
Past Attempts to Harm Self or Others:	☐ None Reported	☐ Self**	☐ Others**			
Self Abuse Thoughts:	☐ None reported	☐ Cutting**	☐ Burning**	☐ Other:		
Suicidal Thoughts:	☐ None reported	☐ Passive SI**	☐ Intent**	☐ Plan**	☐ Means**	
Aggressive Thoughts:	☐ None reported	☐ Intent**	☐ Plan**	☐ Means**		
Comments:						

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Person's Name (First MI Last):	Record #:

Person's Served Strengths/Abilities/Resiliency
(Skills, talents, interests, aspirations, protective factors)

Personal Qualities: (Examples: open, friendly, engaging, motivated, loyal, resourceful, caring, thoughtful)	
Living Situation: (Examples: has maintained long-term stable housing, gets along with living companions)	
Financial/Employment/Education: (Examples: graduated HS, attended college, currently working, hx of working, multiple work skills)	
Health: (Examples: consistent good health, exercises regularly, self cares for health issues as directed by physician, eats nutritional foods)	
Leisure/Recreational/Community Involvement: (Examples: plays a sport, belongs to social group, attends gym, volunteers for Red Cross)	
Natural Supports: (Examples: Family members, clergy, close friends, neighbors, advisors)	
Spirituality/Culture/Religion: (Examples: enjoys religious services, participates in cultural events, meet regularly with rabbi)	

Assessed Needs Checklist Including Functional Domains

Activities of Daily Living
CN = Current Need Area
PD = Person Desires Change Now

CN	PD		CN	PD		CN	PD	
☐	☐	Housekeeping/Laundry	☐	☐	Money Management	☐	☐	Transportation
☐	☐	Housing Stability	☐	☐	Personal Care Skills (includes Grooming/ Dress)	☐	☐	Problem Solving Skills
☐	☐	Grocery Shopping/ Food Preparation	☐	☐	Exercise	☐	☐	Time Management
☐	☐	Medication Management	☐	☐	Safety/Self Preservation			
☐	☐	Other:						

Current Needs Selected Above as Evidenced By:

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Person's Name (First MI Last):	Record #:

Family and Social Supports
CN = Current Need Area
PD = Person Desires Change Now

CN	PD		CN	PD		CN	PD	
☐	☐	Communication Skill	☐	☐	Family Education (Directed at the exclusive well being of the person served)	☐	☐	Peer/ Personal Support Network
☐	☐	Community Integration	☐	☐	Family Relationships	☐	☐	Social/ Interpersonal Skills
☐	☐	Caretaker Obligation Issues	☐	☐	Other:			

Current Needs Selected Above as Evidenced By:

Legal
CN = Current Need Area
PD = Person Desires Change Now

CN	PD		CN	PD	
☐	☐	Legal Issues	☐	☐	Other:

Current Needs Selected Above as Evidenced By:

Employment/ Education/ Finances
CN = Current Need Area
PD = Person Desires Change Now

CN	PD		CN	PD		CN	PD	
☐	☐	Education	☐	☐	Employment/ Volunteer Activities	☐	☐	Meaningful Activities
☐	☐	Financial/Benefits (include VA benefits)	☐	☐	Other:			

Current Needs Selected Above as Evidenced By:

Addictive Behavior and Substance Use
CN = Current Need Area
PD = Person Desires Change Now

CN	PD		CN	PD	
☐	☐	Substance Use/ Addiction (Tobacco, illicit & licit drugs)	☐	☐	Other Addictive Behaviors (food, gambling, exercise, sex etc.)

Current Needs Selected Above as Evidenced By:

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Person's Name (First MI Last):	Record #:

Mental Health/ Illness Management-Behavior Management
CN = Current Need Area
PD = Person Desires Change Now

CN	PD		CN	PD		CN	PD	
☐	☐	Anxiety	☐	☐	Dissociation	☐	☐	Lack of Assertiveness
☐	☐	Anger/ Aggression	☐	☐	Disturbed Reality (Hallucinations)	☐	☐	Mood Swings
☐	☐	Antisocial Behaviors	☐	☐	Disturbed Reality (Delusions)	☐	☐	Obsessions
☐	☐	Coping/ Symptom Management	☐	☐	Gender Identity	☐	☐	Oppositional Behaviors
☐	☐	Cognitive Problems	☐	☐	Grief/Bereavement	☐	☐	Somatic Problems
☐	☐	Compulsive Behavior	☐	☐	Hyperactivity/Hypomania	☐	☐	Stress Management
☐	☐	Depression/Sadness	☐	☐	Impulsivity	☐	☐	Trauma
☐	☐	Other:						

Current Needs Selected Above as Evidenced By:

Physical Health
CN = Current Need Area
PD = Person Desires Change Now

CN	PD		CN	PD		CN	PD	
☐	☐	Health Practices	☐	☐	Pain Management	☐	☐	Sleep Problems
☐	☐	Diet/Nutrition	☐	☐	Sexual Health Issues			
☐	☐	Other:						

Current Needs Selected Above as Evidenced By:

Risk
CN = Current Need Area
PD = Person Desires Change Now

CN	PD		CN	PD		CN	PD	
☐	☐	High Risk Behaviors	☐	☐	Suicidal Ideation	☐	☐	Homicidal Ideation
☐	☐	Other:						

Current Needs Selected Above as Evidenced By:

Person's Name (First MI Last):	Record #:

Other Need Areas
CN = Current Need Area
PD = Person Desires Change Now

CN	PD	
☐	☐	Other:
☐	☐	Other:

Current Needs Selected Above as Evidenced By:

Clinical Formulation – Interpretive Summary

This Clinical Formulation is Based Upon Information Provided By (Check all that apply):
☐ Person Served ☐ Parent(s) ☐ Guardian(s) ☐ Family/Friend(s) ☐ Physician ☐ Records
☐ Law Enforcement ☐ Service Provider ☐ School Personnel ☐ Other:

Interpretive Summary: What in your clinical judgment are the need areas, the factors that led to the needs, and your plan to address them?

Further Evaluations Needed:
☐ None Indicated ☐ Psychiatric ☐ Psychological ☐ Neurological ☐ Medical ☐ Educational
☐ Vocational ☐ Visual ☐ Auditory ☐ Nutritional ☐ SU Assessment
☐ Other:

Was Outcomes tool administered? ☐ Yes ☐ No If Yes, specify:

Diagnosis: ☐ DSM-IV Codes ☐ DSM 5 Codes ☐ ICD-9 Codes ☐ ICD-10 Codes

Check Primary/Billing Diagnosis	Code	Narrative Description
☐		
☐		
☐		
☐		
☐		
☐		

MSDP

Adult Comprehensive Assessment

Person's Name (First MI Last):	Record #:

Prioritized Assessed Needs: AC-Active, PD-Person Declined, DF-Deferred, RE-Referred Out (If declined/deferred/referred out, please provide rationale)	AC	PD*	DF*	RE*
1.	☐	☐	☐	☐
2.	☐	☐	☐	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐

Person Does Not Want A Need Area Included In The IAP Or The Area Is Deferred/Referred Out Rationale(s)
(Explain why Person Declined to work on Need Area; List rationale(s) for why Need Area(s) is/are Deferred/Referred Out below).
☐ None

1.
2.
3.
4.
5.

Person's Service Preferences, Level of Care/Indicated Services Recommendation:

Person Served/Guardian/Family Response To Recommendations:

Person's Signature (Optional, if clinically appropriate)	Date:	**Parent/Guardian Signature** (If appropriate):	Date:
Clinician/Provider - Print Name/Credential:	Date:	**Supervisor - Print Name/Credential** (if needed):	Date:
Clinician/Provider Signature:	Date:	**Supervisor Signature** (if needed):	Date:
Psychiatrist/MD/DO (If required):	Date:	**Next Appointment:** Date: Time: ☐ am ☐ pm	

7.3.D. INNOVATIVE TECHNOLOGIES FOR SERVICE DELIVERY

Through a SAMHSA HIT grant, CSO developed a set of technology tools to support clients in a variety of recovery programs. These have achieved national recognition and were presented in a 2014 White House Drug Conference.

Video conferencing: The use of videoconferencing for treatment allows CSO clinicians to provide two major types of services from any of our outpatient treatment hubs to any other CSO site in outlying areas: Direct clinical services and training/supervision. The interventions will involve therapy directly with clients. In addition, we will establish support groups targeted toward those in treatment and recovering from substance abuse for interactive televising. Specialty consultation for clinical care management staff and care coordinators can be accessed throughout the region utilizing this equipment.

Text4Recovery - Use of technology to enhance treatment collaboration: We have a text-messaging platform to serve multiple functions: 1. Chat: patients send in a question and have it answered by a clinician or case manager. 2. Motivational messaging: A motivational message is sent out to all subscribers on a daily basis. This messaging serves to enhance engagement and maintain connections to clients. To protect patient confidentiality, questions sent via text come to a password protected on-line platform. Text messages can either be sent at the time of writing or be programmed by staff for delivery at a predetermined date and time through Credible.

Web Site services and interactive health portal:

Resources Inventory: Listings of services, support groups, and personal advocacy resources in catchment area communities; CBOs for housing employment, legal services, etc.; schedules and directions to NA/AA meetings, inspirational literature; will have semi-annual updating.
Linkages: Links directly to recovery-related Websites and discussion groups, on line meetings, community based recovery supports.

Credible Client Portal: In the Credible Client Portal, a client, family member, or other client contact, with appropriate consents can view different parts of the client's record such as treatment plans, service history and summary, medications, and family members. Using the Messaging function in the Client Portal, a client user can send a refill request for a current medication, a message about a scheduled appointment, or a general message. The Client Portal is slated for innovations that will allow us and clients to update their demographic information, contacts, complete assessment tools, complete administrative paperwork, participate in Quality Assurance surveys, and receive clinical support documents from their providers.

Credible Care Management Tools: The Credible Care Management tools are described in 7.2.E. They will enable multiple members of the Care Team track the Care Plan and progress toward goals and provide input. This systems allows staff to reconcile medications for prescribing staff. It provides us with the ability to report on internal and external case coordination.

Smart Phone and Tablet/iPad apps: The Care Management team and Wellness coordinator will utilize appropriate, existing smart phone and tablet app's to enhance motivation for adherence to programs and help encourage interactive participation in health and wellness activities; activities related to self-management of symptoms and behavioral tracking; and other related tools. The Wellness coordinator will keep an ongoing "top list" of app's to be shared with Care Coordinators, Nurses, Clinical Care Managers and Enrolled Members so there is consistency in training and tracking of recommended tools.

7.3.E. PERSONNEL AND STAFFING

Programmatic Organizational Chart and Job Descriptions for program staff are attached at the end of 7.3.E.

CP Program Director will be a full-time position in the program; a licensed behavioral health clinician with significant management experience in community-based programs, demonstrated skill at inter-agency collaboration and a strong commitment to the CP role. The Director will supervise all other managers in the program.

Medical Director will be a psychiatrist assigned 0.2 FTE to provide case consultation to teams or individual CP staff concerning Members, as well as participating with the CP management team in establishing policies and procedures for the programs.

Nurse Managers – We will open the program with 3 FTE nurse managers, shared among the 5 service areas, proportionally to volume. We will increase to 4 FTEs by the end of Year 1 and to at least 4.5 FTEs during Year 2. These staff will have at least an RN license and may have additional degrees or credentials.

Outreach Nurse – At the start of the program, we will have one full-time nurse to do transition-of-care outreach to Members discharged from inpatient care; if volume indicates, we will add to this position over the course of the program. In times when the outreach nurse is absent or volume is unpredictably time, the outreach nurse will be backed up by the nurse managers.

Clinical Care Manager (CCM) Supervisor – We will start the program with one FTE CCM supervisor and add a second supervisor in Year 2. These individuals will be senior licensed clinicians, with supervisory experience.

Clinical Care Managers – At the start, we will have 4 CCMs, adding staff throughout Year 1 to meet demand. We expect to have 10 FTEs by the end of Year 1 and add 2 more FTEs during Year 2, continuing at that level through the 5-year contract period unless volume requires an adjustment up or down. CCMs will meet the license and other credential requirements of Attachment A, as amended.

Care Coordinator/Peer Coach Supervisors – We will open the program with 2 FTE supervisors, adding a third FTE in Year 2. These supervisors will be Masters-level behavioral health clinicians with experience supervising para-professional staff in community-based services. They will also have training specific to supervision of peer staff.

Care Coordinators – We will open the program with 12 Care Coordinators, adding staff throughout Year 1 to reach 27 FTEs by the end of Year 1. We will continue to add staff through Year 2, reaching up to 35 FTEs if volume requires. This level of staffing will remain through the 5-year contract period unless volume requires an adjustment up or down. Care Coordinators will individuals who are trained in working with adults who have SMI and/or SUD. They may have experience as Community Health Workers, outreach workers, CSP workers, recovery coaches or related work.

Peer Coach is a term we use broadly to include any para-professional staff who brings his/her lived experience to the work of supporting clients. They may serve as recovery coaches, wellness coaches, crisis or trauma specialists, or more generally as Care Coordinators. We plan to open the program with 4.5 FTEs and add staff during Year 1, ending with at least 8 FTEs. During Year 2 we expect to continue to add peer staff, reaching 9.5 FTEs. We will retain a flexible roster of Peer Coaches, depending on the availability of qualified candidates for hire (i.e., some of the Care Coordinators indicated above may be peers, so that we have more peers, but the same combined number of FTEs

The Director will also provide individual or small group supervision to the managers on a periodic basis, with a schedule that fits the program's and staffs' needs. The Director, in turn, will be supervised by CSO Vice President Sandi Walters, LICSW. Ms. Walters will also attend the CP Management Team meetings as the prep begins, in the early phase of operations, and intermittently as appropriate both to monitor the ongoing work and to help address specific issues that may arise. Ms. Walters will be easily accessible to the Director at all times by cell phone, text and email.

Staff Supervision: Each supervisor will be responsible for overseeing assigned staff in two or three service areas. They will be physically present at each assigned site on at least a weekly basis—adjusting their schedules to accommodate volume of staff and cases and any particular circumstances that warrant a greater or lesser volume of supervision (e.g., seasoned staff v. less experienced staff).

The CSO supervision process includes skill assessment, individual and group sessions reviewing current work, coaching, records review, grand rounds participation, and probationary period performance reviews, followed by annual performance evaluations. There are regularly scheduled team meetings, at least monthly, for collaboration and coordination among all BH CP staff. It is expected that there will be regular ad hoc team meetings and dyad supervision between Care Managers and Care Coordinators to collaborate on shared cases.

Performance Improvement coaching is a tool that may be used to identify performance deficiencies and specify corrective actions to facilitate that employee's improvement and, hopefully, his or her ultimate success within the organization. Performance reviews are used not only as a step in performance evaluation, but also to jointly create performance goals and professional development plans for all staff relating directly to needed core competencies.

Staff Recruitment and Retention

Beginning immediately at the notification of award, CSO will begin aggressive recruitment strategies to fill all BH CP positions. Recruiting will begin with Leadership positions, and move to recruitment of direct care and nursing positions over the initial ramp up period. Our goal would be to have the base staff in place at least 30 days prior to accepting assignments, to ensure adequate time for orientation, training, community outreach and policy and procedure development. We are accustomed to staffing to volume after program start-ups, and will closely monitor volume of assignments, referrals and need for adding staff throughout the life of the BH CP program, adjusting upwards or downwards accordingly.

Recruitment strategies include:

- Internal promotion and advancement opportunities for current staff, especially those already trained in the Integrated Care and Care Coordination modules;
- Web-based classified advertising (this includes Indeed.com, Craigslist, and industry-related websites like National Council for Behavioral Health, NQCC and Human Service Forum). We have had very good experience in 2017 with an enhanced presence on Indeed.com. We intend to replicate this strategy that has been used agency-wide, specifically for the CP program during the prep phase and Year 1, when we will be continuously recruiting a large number of staff. Our budget provides for this enhanced cost of online recruitment.
- CSO website – vacancy posting and online application
- Online and on-site position vacancy postings at area colleges and universities
- A robust internship program – CSO has approximately 20 interns at any given point in time, which results in hiring of many interns upon successful completion of internship and schooling.

- Tuition reimbursement for CSO staff to pursue advanced degrees, with a commitment to stay at CSO for a minimum period of time post-completion.
- Robust training availability, including free CEU's for social workers, LMHC's and LMFT's.
- Word of mouth and employee referral bonus – mostly from employees (internal referrals, including a referral bonus paid to CSO employees who refer a candidate who is hired for targeted positions).
- Job fairs and college recruitment events;
- Use of specialized recruitment firms for targeted positions (ie; Nurse managers, etc).

CSO has a system of "growing our own" clinicians and conducting aggressive recruitment of qualified clinicians and staff. Our first priority is to promote from within so that supervisory staff are oriented to CSO and steeped in its philosophy. We also provide an extensive training program to prepare staff to work in their programs. CSO has developed a cross-training and resource sharing strategy of training outpatient and CBHI clinicians for crisis work to add depth of capacity and flexibility in staffing patterns.

CSO has an agency-wide Internship Program. Currently we have formal intern placement agreements with over 10 area Colleges and Universities. We have up to 20 second year Masters level interns and multiple PhD candidate interns at any given point in time serving placements within our Outpatient, Family Support and Crisis services programs. We have a history of retaining over 70% of our interns for permanent employment in CSO programs.

CSO has a long history of recruiting clinical and direct care staff that represent the population we target both culturally and with expertise in areas of trauma and working with high risk Members. We also observe a policy to recruit and promote from within the organization. Generally we give preference to applicants who have lived experience. Many CSO staff live in the community they serve, and are aware firsthand of the challenges and opportunities that our clients' face. CSO recruits staff qualified to work with culturally and linguistically diverse people, and we emphasize hiring staff that mirror the cultures and languages of families in the program.

Staff retention strategies: CSO has been very successful in retaining staff. Many of CSO's current staff have longevity with the program and come to us with previous experience. Most of our current supervisory team have been with the agency for over 10 years, with several over 15. Our staff tenure rate has steadily increased each year over the last 5 years.

CSO's employs innovative as well as traditional retention strategies. Our extensive training program facilitates the acquisition of new skills and certifications in order that staff may seek higher levels of professional attainment. Cross training is one means of creating flexible staffing resources. Our staff can move from program to program and have found it an excellent strategy for professional development. Being part of a supportive team environment contributes to high staff morale. CSO offers a competitive pay scale and generous benefits compared to other agencies in the region. CSO attends to staff morale with incentives and financial support for further professional education and an employee recognition program, awards and events.

CSO's track record of staff continuity supports program stability and consistency in staffing patterns and scheduling. CSO invests in benefit structures and morale activities to encourage retention. Staff have generous time off policies including vacation, personal and sick leave; vast training opportunities (over 450 hours of on site, free training with free CEU's was offered to staff last year); generous staff referral bonus; guaranteed annual salary increases; premier health and dental plans paid by the agency at 75%; training and tuition reimbursement opportunity; on

site morale budgets; agency-wide morale activities like company picnics and a staff appreciation celebration with Annual Staff award honorees; and a culture of continuous quality improvement that is invested in staff and consumer feedback and multi-level QI workgroups. Over 60% of CSO's current management team was derived from internal promotions.

Staff Training

All newly hired staff at CSO undergo both group and individual new hire orientation that includes topics such as agency history, mission and values; orientation to CSO programs; ethical and legal compliance; policies/procedures; benefits overview; HIPAA; safety.

In addition to the general new employee orientation, all CP staff will go through an exhaustive training that includes program specifications and requirements; Credible orientation and utilization; conducting comprehensive assessments; Individual Action Plan and the role of the Care Team; Risk Management and safety planning; area specific community resources; Principles of Rehabilitation & Recovery; Peer Support; Engagement, Building Relationships & Boundaries; Cultural competency and serving linguistic minority populations (including Deaf/Hard of hearing); and the four CSO Integrated Care Modules (see below), and Nonviolent Crisis Intervention using CPI (Crisis Prevention Institute).

CP staff will also be encouraged to attend EBP trainings such as Motivational Interviewing, Seeking Safety, SBIRT administration and interpretation, and others as offered.

CSO assesses the skills and competence of each staff member and, as necessary, provides in-service training and education programs. Our Human Resources department has written policies and procedures describing CSO's methods of assessing competency and maintains documentation of the in-service training provided to each employee. CSO documents in the staff personnel records that the training and demonstration of competency are successfully completed.

CSO has implemented an innovative staff training program for all CSO staff. I*ntegrated Health Treatment Education and Training* (IHTET) is a program of education and training to develop general skills for mental health practitioners/professionals in engaging patients, promoting their self-efficacy to improve their own health, using general medical knowledge to be able to connect them to appropriate services, to address questions and to support client-directed integrated treatment planning that include physical health and wellness goals. BH CP staff will be required to attend all of the IHTET modules, described below, as part of their orientation and ongoing training.

The modules of the IHTET program are:
Module I: Introduction to Integrated Behavioral Health Practice
Module 2a: Mini Medical School for the Behavioral Health Provider
Module 2b: Basic Principles of Psychopharmacology; Cultural Competence in Integrated Care
Module 3: Improving Health and Wellness Behaviors – Clinical Strategies
Module 4: Coordinated and Integrated Behavioral Health Practice

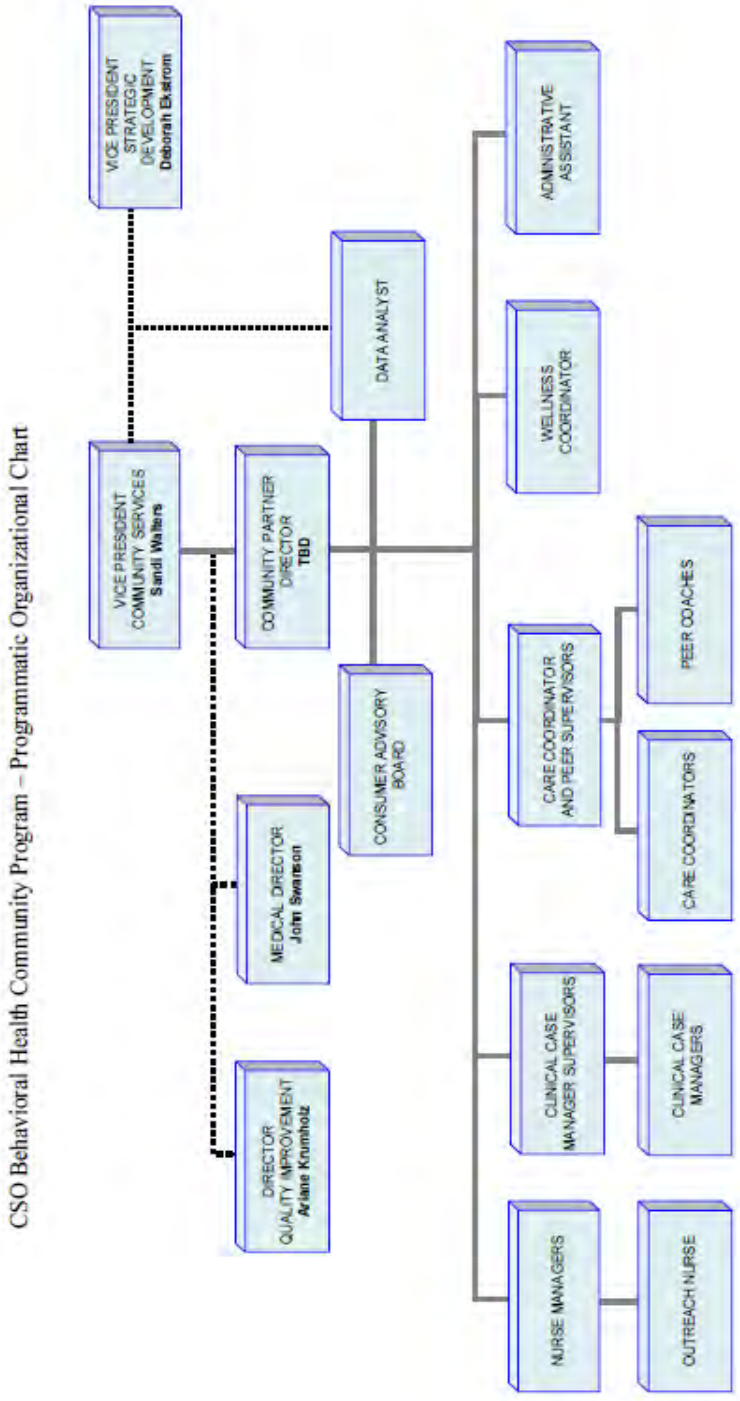
The training program enables CSO staff to (1) support people who are coping with chronic illnesses that put their health and/or social functioning at risk; and (2) use an integrated approach to addressing health problems and finding solutions. The course offers certification at two levels: basic, for all CSO staff; and advanced practice, for those who have care coordination or care management responsibilities.

Through IHTET, CSO staff are trained to offer:

- Development of hierarchy of client needs, physical and mental, to help clients to make a plan that they can follow through to address these needs;
- Support for clients in "buying in" to their own self-care;

- Help for clients to overcome fears concerning meds, procedures, surgeries, etc., helping them attain a healthy point of view about their bodies and medical conditions and understanding the relationship between physical and mental health;
- Client education on how to talk to their doctors and feel heard, to be aware of their medical conditions and to be proactive in preventive care;
- Encouragement to use their PCP and not the ER for routine health care needs;
- Documentation of Client medical profile fields and ensure medical/wellness goals are addressed in an Integrated treatment plan.

ATTACHMENT: PROGRAMMATIC ORGANIZATIONAL CHART



ATTACHMENT: JOB DESCRIPTIONS FOR PROGRAM STAFF

JOB DESCRIPTION

TITLE: Director of Community Partner (CP) program

PURPOSE: To provide overall administrative and programmatic oversight of the Community Partner (CP) program including program leadership; maintaining relationships with external stakeholders, including ACOs, MCOs, other CPs, providers across the medical/BH/LTSS spectrum, other community and human services organizations, and client/family advocacy groups; supervision of CP managers. Additionally, the Director is primarily responsible for the design and implementation of orientation and training of CP program staff; staffing the CP Consumer Advisory Board; and ensuring compliance with all aspects of the Mass Health CP contract.

LINE OF RESPONSIBILITY: The Director of CP reports to the Vice President for Community Services.

ESSENTIAL RESPONSIBILITIES:

1. Provide administrative, clinical, and operational management of CP program.
2. Provide supervisory support to Nurse Managers, Care Management Supervisors, Care Coordination/ Peer Supervisors, Wellness Coordinator and Administrative Assistant. Assist each in creating effective workflows, processes and performance standards.
3. Work collaboratively to coordinate program development and teambuilding with all CP staff.
4. Provide clinical consultation and guidance to CP staff/supervisors. Assist in resolving issues with other providers, ACOs, MCOs, other stakeholders.
5. Facilitate management team and program staff meetings.
6. Maintain regular communication with contacts at ACOs, MCOs and subcontractors.
7. Provide continual program monitoring to assure that program is meeting quality standards, targeted volume/productivity, and financial metrics.
8. Facilitate quarterly meetings of the CP Consumer Advisory Board (CAB); ensure that CAB members are appropriately oriented to the CP's role and receive timely data and qualitative reports necessary to fulfill their responsibilities.
9. To oversee orientation of new staff to Wraparound in the first four weeks of employment and to work closely with site ICC supervisors to train and credential new ICC and FP staff within 6-9 months of employment.
10. Ensure staffing of the program, consistent with contract and service needs. Work with HR and program supervisors on timely recruitment and hiring.
11. Facilitate quarterly meetings of area providers to discuss CP work, advise about status of healthcare delivery system reform, and share information across programs and services.
12. Be available to work flexible schedule which may include evening and weekend work and availability by phone or pager to supervise and assist with plan implementation, as required by the needs of the program.

13. Utilize clinical and training expertise to provide leadership and guidance to staff, families and care planning teams for complex family presentations requiring advanced clinical management skills.
14. Act as a resource to ICC Supervisors during the CSA credentialing process.
15. Maintain complete, accurate and timely records.
16. Maintain regular communication with ACO's, MCE's, material subcontractors, and providers throughout the region.
17. Attend staff and Agency Management meetings as directed.
18. Adhere to the philosophy of "customer satisfaction" and consistently follow the same by providing reliable, responsive, consistent and high quality service in a timely manner to staff and external customers.
19. Support and maintain a high performance environment characterized by positive leadership and a strong team orientation as an added value member of the Agency Management team; support CEO-approved goals and philosophies, sharing a fundamental philosophy that enhances the agency's global reputation within the community.
20. Communicate regularly with staff on progress toward defined goals of Agency Management team; if required, complete and conduct annual performance evaluations in a timely fashion, providing specific feedback and work with HR to initiate corrective action when defined goals and/or required results are not met.
21. Motivate staff to embrace the philosophies and goals of the Agency Management team.
22. Attend all scheduled individual and group supervision.
23. Follow all agency policies and procedures.
24. Perform other duties as assigned by supervisor.

QUALIFICATIONS: Masters Degree in Psychology, Counseling, Social Work or closely related field from an accredited program. The Director will have experience in care management/care coordination, supervision of both clinicians and paraprofessional staff, and managing inter-agency relations. Demonstrated experience working with adults with SMI and SUD, navigating systems of care and supports within the community. Good listening skills, nonjudgmental ability to develop staff strengths, capacity to create and lead an effective team. Demonstrated sensitivity to the needs of individuals from diverse cultural or linguistic backgrounds. Ability to establish trusting relationships through compassion, empathy and insight. Computer proficiency required including ability to work with email, electronic health record and word processing software.

JOB DESCRIPTION

Title: CP MEDICAL DIRECTOR

Purpose: To collaborate in the development of clinical policies and procedures for the CP program; services; to provide consultation on individual Member issues or program clinical issues as requested by the CP Director, a Nurse Manager, or CCM Supervisor; to communicate with other physicians, clinicians, or administrators regarding patient or policy issues, upon request; to provide in-service training or coaching to CP staff; to provide other clinical support to the program as needed.

Line of Responsibility: The Medical Director is responsible to the Chief Executive Officer.

CP Responsibilities:

1. Collaborate with CP managers in the development of clinical policies, procedures and protocols for the CP program.
2. Provide consultation regarding clinical policies, practices and interactions with other providers, ACOs or MCOs.
3. Provide review and assessment of individuals' medications, treatment recommendations and/or Care Plans, upon request of the CP Director, a Nurse Manager, or a CCM Supervisor.
4. Communicate with medical staff of other providers, ACOs or MCOs as requested to provide consultation or resolve differences.
5. Maintain complete, accurate and timely records.
6. Represent the agency in a positive manner and maintain good working relationships with other agencies and professionals.
7. Attend job related meetings.
8. Other related duties as determined by the Chief Executive Officer or designee.

Qualifications: Must be Board certified in psychiatry. Must hold a valid Massachusetts license to practice medicine. Experience working with adults who have serious mental illness and substance use disorders is required. Computer proficiency required including ability to work with email, electronic health record and word processing software.

JOB DESCRIPTION

TITLE: CP NURSE MANAGER

PURPOSE: To provide clinical assessment, evaluation and planning services for Mass Health Members; participate in Care Teams and Care Plan development; provide consultation to CCMs and other CP staff as needed to evaluate medical needs and treatment plans for enrolled Members; assist in communication with medical providers, Members and families as needed; provide in-service training and coaching for CP staff; participate in development of transition plans for Members discharged from inpatient care; conduct medication reconciliation and other transition support activities as needed.

LINE OF RESPONSIBILITY: The Nurse Manager reports to the CP Director.

ESSENTIAL RESPONSIBILITIES:

1. Collaborate with CCMs in the Comprehensive Assessment and care planning of engaged Members, providing expertise in medical assessment and treatment planning.
2. Participate in Care Teams as appropriate for individual Members.
3. Provide in-service training for CP staff on common medical issues and appropriate treatment, intervention and support strategies.
4. Provide case consultation pertaining to medical issues for CCMs and other CP staff as requested.
5. Communication with non-CP members of Care Teams (e.g., hospital staff, PCPs, nursing

home staff) as needed to support and advance appropriate care for Members.
6. Participate on CP management team in the development of clinical policies and procedures, service protocols, workflows and other operational matters.
7. Conduct medication reviews and monitoring as needed.
8. Participate in the development of transition-of-care plans for Members discharged from inpatient care.
9. Collaborate with Outreach Nurse in the development, adaptation and execution of transition plans, including medication reconciliation and patient education as appropriate. Provide back-up/replacement for Outreach Nurse as needed.
10. Maintain regular communication with ACOs, MCOs, providers and other stakeholders, as appropriate to duties.
11. Maintain complete, accurate and timely records.
12. Participate in CP management and staff meetings.
13. Participate in individual and group supervision.
14. Follow all agency policies and procedures.
15. Perform all other duties as assigned.

QUALIFICATIONS: Must be licensed in Massachusetts as a Registered Nurse, and have a minimum of three years' experience treating adults. Related degree preferred. Experience treating individuals with serious mental illness and substance use disorders preferred. Primary care experience strongly preferred. Must be familiar with community resources and possess good communication and interpersonal skills. Ability to establish trusting relationships through compassion, empathy and insight. Capacity to be an effective member of a Team. Demonstrated sensitivity to the needs and perspectives of individuals from diverse cultural or linguistic backgrounds. Computer proficiency required including ability to work with email, electronic health record and word processing software.

JOB DESCRIPTION

TITLE: CP OUTREACH NURSE

PURPOSE: To provide clinical assessment, evaluation, monitoring and education to Mass Health Members on an outreach basis—in their own homes or other residential settings. Collaborate with Nurse Managers, Clinical Care Managers and Care Coordinators to ensure optimal planning and support for Members discharged from inpatient care. Provide outreach to other Members as assigned.

LINE OF RESPONSIBILITY: The Outreach Nurse reports to the Nurse Manager.

ESSENTIAL RESPONSIBILITIES:
1. Collaborate with Nurse Managers, Clinical Care Managers (CCMs) and Care Coordinators (CCs) in the development of transition-of-care plans for Members who are discharged from inpatient care and other patients in need of in-home CP nurse visits.
2. Conduct nursing visits to assigned Members in their homes or other residential settings. Visit shall include brief assessment and evaluation, provision of planned care, medication reconciliation, and patient education and support to assist them with self-management of

their care.
3. During outreach visit, communicate with family members or other caregivers regarding the patient's care as appropriate and permitted by the patient.
4. Following (or during) outreach visit, coordinate with CCM and/or CC as appropriate regarding further care and support for the patient.
5. Participate in Care Teams as appropriate for individual Members needing ongoing outreach.
6. Provide in-service training for CP staff on common medical issues and appropriate treatment, intervention and support strategies.
7. Provide case consultation pertaining to medical issues for CCMs and other CP staff as requested.
8. Communicate with non-CP members of Care Teams (e.g., hospital staff, PCPs, nursing home staff) as needed to support and advance appropriate care for Members.
9. Conduct medication reviews and monitoring as needed.
10. Maintain complete, accurate and timely records.
11. Participate in CP staff meetings.
12. Participate in individual and group supervision.
13. Follow all agency policies and procedures.
14. Perform all other duties as assigned.

QUALIFICATIONS: Must be licensed in Massachusetts as a Registered Nurse, and have a minimum of three years' experience treating adults. Related degree preferred. Experience treating individuals with serious mental illness and substance use disorders preferred. Primary care experience strongly preferred. Must be familiar with community resources and possess good communication and interpersonal skills. Ability to adapt to a variety of environments and make decisions when faced with unplanned circumstances. Ability to establish trusting relationships through compassion, empathy and insight. Capacity to be an effective member of a Team. Demonstrated sensitivity to the needs and perspectives of individuals from diverse cultural or linguistic backgrounds. Computer proficiency required including ability to work with email, electronic health record and word processing software.

JOB DESCRIPTION

TITLE: CARE MANAGEMENT SUPERVISOR (COMMUNITY PARTNER PROGRAM)

PURPOSE: To provide daily administrative and programmatic supervision of Clinical Care Managers (CCM), including development of Care Teams, coordinating the development of Care Plans, risk management/safety plans, and transition of care plans. The Supervisor ensures that the program's clinical policies and procedures are followed; that CCMs are adequately oriented, trained and supported; conducts individual and group supervision; monitors and evaluates CCM performance; works with the program management team to ensure effective and efficient workflows and operations in adherence to contract.

LINE OF RESPONSIBILITY: The Care Management Supervisor reports to the CP Director.

ESSENTIAL RESPONSIBILITIES:
1. Provide regular administrative, clinical, and care management supervision of CCMs.

2. Recruit, orient and train qualified clinicians to serve as CCMs, maintaining staffing level appropriate to volume of enrolled Mass Health Members.
3. Work collaboratively with CP management team to coordinate program development and teambuilding among all CP staff. Establish workflows for CCM duties, in collaboration with the CP management team.
4. Provide clinical consultation and guidance to CCM staff (and other staff, upon request), ensuring clinically informed care plans Enrollees.
5. Facilitate care planning team (CPT) meetings as necessary and educate staff on the facilitation of meetings.
6. Provide direct CCM services when a CCM is absent and Member services are needed during the absence.
7. Provide assistance to staff and community participants with systems navigation and coordination.
8. Assist staff in resolving issues with other providers, ACOs, MCOs, other stakeholders.
9. Be available to work flexible schedule which may include evening and weekend work and availability by phone or pager to supervise and assist with plan implementation, as required by the needs of the program.
10. Utilize clinical and training expertise to provide leadership and guidance to staff, families and care planning teams for complex family presentations requiring advanced clinical management skills.
11. Maintain complete, accurate and timely records.
12. Maintain regular communication with ACOs, MCOs, providers and other stakeholders, as appropriate to duties.
13. Attend staff and Agency Management meetings as directed.
14. Adhere to the philosophy of "customer satisfaction" and consistently follow the same by providing reliable, responsive, consistent and high quality service in a timely manner to staff and external customers.
15. Support and maintain a high performance environment characterized by positive leadership and a strong team orientation as an added value member of the Agency Management team; support CEO-approved goals and philosophies, sharing a fundamental philosophy that enhances the agency's global reputation within the community.
16. Communicate regularly with staff on progress toward defined goals of Agency Management team; if required, complete and conduct annual performance evaluations in a timely fashion, providing specific feedback and work with HR to initiate corrective action when defined goals and/or required results are not met.
17. Motivate staff to embrace the philosophies and goals of the Agency Management team.
18. Attend all scheduled individual and group supervision.
19. Follow all agency policies and procedures.
20. Perform other duties as assigned by supervisor.

QUALIFICATIONS: Master's Degree in Psychology, Counseling, Social Work or closely related field from an accredited program. Mass. licensure required. Experience required in working with adults with SMI/SUD and in supervising clinical staff. Must possess skills in providing education and planning regarding treatment access and service needs, conflict resolution, risk management/safety planning, client advocacy and support. Good listening skills, nonjudgmental ability to develop staff strengths, capacity to create and lead an effective team.

Ability to establish trusting relationships through compassion, empathy and insight. Capacity to be an effective member of a Team. Demonstrated sensitivity to the needs of individuals from diverse cultural or linguistic backgrounds. Computer proficiency required including ability to work with email, electronic health record and word processing software.

JOB DESCRIPTION

TITLE: CP CLINICAL CARE MANAGER (CCM)

PURPOSE: To engage assigned and referred Mass Health Members in CP services; to conduct Comprehensive Assessments of engaged Members; to facilitate Care Teams and the development of Care Plans for Members; to make referrals and linkages to services and supports for the Member, in accordance with the Care Plan and the Members' wishes; to maintain connection with the Member at a frequency and in a manner that meets the Member's preferences and expectations. CCMs work in collaboration with Nurse Managers, Care Coordinators, Peer Coaches and other Care Team members to provide the best possible services for Members.

LINE OF RESPONSIBILITY: The Clinical Care Manager reports to the Care Management Supervisor.

ESSENTIAL RESPONSIBILITIES:

1. Provide telephone or other electronic outreach to assigned and referred Members, as cases are assigned, to determine whether they wish to enroll in CP services. Use Motivational Interviewing approach and other established engagement strategies to help Members engage.
2. In collaboration with current primary care, BH and other providers, develop Comprehensive Assessment and establish Care Team for each Member, supporting the care planning process.
3. Facilitate the development of an individualized Care Plan for each Member, reflecting the input of all Care Team participants and the Member's wishes.
4. Make referrals and linkages to appropriate services along the continuum of care, consistent with the Care Plan.
5. Develop and manage transition-of-care plans for Members discharged from inpatient care.
6. Maintain regular contact with Members, in a manner and at a frequency that is consistent with the Care Plan and the Members' preferences and expectations.
7. Provide wellness resources for Members.
8. Assist members (and families, as appropriate) with system navigation.
9. Work collaboratively with all members of Care Teams and CP teams (including Nurses, Care Coordinators, Peers).
10. Maintain complete, accurate and timely records.
11. Meet and maintain expected caseload/productivity level.
12. Participate in all staff meetings as required.
13. Participate in all scheduled individual and group supervision.
14. Follow agency policies and procedures.
15. Perform all other duties as assigned.

QUALIFICATIONS: Master's Degree in Psychology, Counseling, Social Work or closely related field from an accredited program. Mass. licensure required. Experience required in working with adults with SMI/SUD. Must possess skills in providing education and planning regarding treatment access and service needs, conflict resolution, risk management/safety planning, client advocacy and support. Good listening skills, nonjudgmental ability to develop staff strengths, capacity to create and lead an effective team. Ability to establish trusting relationships through compassion, empathy and insight. Capacity to be an effective member of a Team. Demonstrated sensitivity to the needs and perspectives of individuals from diverse cultural or linguistic backgrounds. Computer proficiency required including ability to work with email, electronic health record and word processing software.

JOB DESCRIPTION

TITLE: CARE COORDINATION/PEER SUPERVISOR (COMMUNITY PARTNER PROGRAM)

PURPOSE: To provide daily administrative and programmatic supervision of Care Coordinators (CC) and Peer Coaches, including outreach to and engagement of assigned and referred Mass Health Members, coordination with providers of services and support, participation in the development of Care Plans, risk management/safety plans, recovery coaching, ongoing support and wellness education, and transition of care plans. The Supervisor ensures that the program's policies and procedures are followed; that CCs and Peers are adequately oriented, trained and supported; conducts individual and group supervision; monitors and evaluates CC and Peer performance; works with the program management team to ensure effective and efficient workflows and operations in adherence to contract.

LINE OF RESPONSIBILITY: The Care Coordination/Peer Supervisor reports to the CP Director.

ESSENTIAL RESPONSIBILITIES:

1. Provide regular administrative, clinical, and relational/logistical supervision of CCs and Peers.
2. Recruit, orient and train qualified individuals to serve as CCs and Peers, maintaining staffing level appropriate to volume of enrolled Mass Health Members.
3. Work collaboratively with CP management team to coordinate program development and teambuilding among all CP staff. Establish workflows for CC and Peer duties, in collaboration with the CP management team.
4. Provide clinical consultation and guidance to CC and Peer staff (and other staff, upon request), ensuring clinically-informed and recovery-based care plans Enrollees.
5. Provide direct CC services when a CC is absent and Member services are needed during the absence.
6. Provide assistance to staff and community participants with systems navigation and coordination.
7. Assist staff in resolving issues with other providers, ACOs, MCOs, other stakeholders.

8. Be available to work flexible schedule which may include evening and weekend work and availability by phone or pager to supervise and assist with plan implementation, as required by the needs of the program.
9. Utilize clinical and training expertise to provide leadership and guidance to staff, families and care planning teams for complex family presentations requiring advanced clinical management skills.
10. Maintain complete, accurate and timely records.
11. Maintain regular communication with ACOs, MCOs, providers and other stakeholders, as appropriate to duties.
12. Attend staff and Agency Management meetings as directed.
13. Adhere to the philosophy of "customer satisfaction" and consistently follow the same by providing reliable, responsive, consistent and high quality service in a timely manner to staff and external customers.
14. Support and maintain a high performance environment characterized by positive leadership and a strong team orientation as an added value member of the Agency Management team; support CEO-approved goals and philosophies, sharing a fundamental philosophy that enhances the agency's global reputation within the community.
15. Communicate regularly with staff on progress toward defined goals of Agency Management team; if required, complete and conduct annual performance evaluations in a timely fashion, providing specific feedback and work with HR to initiate corrective action when defined goals and/or required results are not met.
16. Motivate staff to embrace the philosophies and goals of the Agency Management team.
17. Attend all scheduled individual and group supervision.
18. Follow all agency policies and procedures.
19. Perform other duties as assigned by supervisor.

QUALIFICATIONS: Master's Degree in Psychology, Counseling, Social Work or closely related field from an accredited program. Experience required in working with adults with SMI/SUD, supervising paraprofessional staff, and working with peer staff. Must possess skills in providing education and planning regarding treatment access and service needs, conflict resolution, risk management/safety planning, client advocacy and support. Good listening skills, nonjudgmental ability to develop staff strengths, capacity to create and lead an effective team. Ability to establish trusting relationships through compassion, empathy and insight. Capacity to be an effective member of a Team. Demonstrated sensitivity to the needs and perspectives of individuals from diverse cultural or linguistic backgrounds. Computer proficiency required including ability to work with email, electronic health record and word processing software.

JOB DESCRIPTION

TITLE: CP CARE COORDINATOR

PURPOSE: To engage assigned and referred Mass Health Members in CP services; to participate in Care Teams and the development of Care Plans for Members; to coordinate services and supports for the Member, in accordance with the Care Plan and the Members' wishes; to maintain connection with the Member at a frequency and in a manner that meets the Member's preferences and expectations. Care Coordinators work in collaboration with Clinical

Care Managers, Peer Coaches and other team members to provide the best possible services for Members.

LINE OF RESPONSIBILITY: The CP Care Coordinator reports to the Care Coordination/Peer Supervisor.

ESSENTIAL RESPONSIBILITIES:

1. Provide telephone, other electronic, or in-person outreach to assigned and referred Members, as cases are assigned, to determine whether they wish to enroll in CP services. Use Motivational Interviewing approach and other established engagement strategies to help Members engage.
2. Assist CCM in development of Comprehensive Assessment and Care Team for each Member, supporting the care planning process.
3. Provide care coordination among providers, according to the Care Plan and Member's wishes.
4. Provide logistical and practical support to Member in accessing services and meeting needs.
5. Provide wellness resources, including training and assistance with activities, for Members.
6. Maintain regular contact with Members, in a manner and at a frequency that is consistent with the Care Plan and the Members' preferences and expectations.
7. Make referrals and linkages to appropriate services along the continuum of care, consistent with the Care Plan.
8. Assist members (and families, as appropriate) with system navigation.
9. Be available to work flexible schedule which may include evening and weekend work, as required by the needs of Members receiving services.
10. Work collaboratively with all members of Care Teams and CP teams (CCMs, CCs, Peers).
11. Maintain complete, accurate and timely records.
12. Meet and maintain expected caseload/productivity level.
13. Participate in all staff meetings as required.
14. Participate in all scheduled individual and group supervision.
15. Follow agency policies and procedures.
16. Perform all other duties as assigned.

QUALIFICATIONS: Bachelors degree from an accredited college or university preferred. Certification as a Community Health Worker is a plus. Experience providing services and supports to adults with SMI/SUD. The care coordinator is skilled in providing education and planning regarding treatment access and service needs, parenting skills, conflict resolution mediation, risk management/safety planning, family advocacy and support. Good listening skills, nonjudgmental ability to foster self-sufficiency. Ability to establish trusting relationships through compassion, empathy and insight. Capacity to be an effective member of a team. Demonstrated sensitivity to the needs and perspectives of people from diverse cultural or linguistic backgrounds. Computer proficiency required including ability to work with email, electronic health record and word processing software.

JOB DESCRIPTION

TITLE: CP PEER COACH

PURPOSE: The CP Peer Coach provides hope, mutual peer support, advocacy, purposeful sharing of lived experience, and education to Mass Health Members receiving CP services. Peer staff also model and inform other CP staff about recovery. Peers provide care coordination services, advocacy, crisis support, wellness information and support, and participation on Care Teams.

LINE OF RESPONSIBILITY: Reports to the Care Coordination/Peer Supervisor.

PEER STAFF RESPONSIBILITIES:

1. Provide telephone, other electronic, or in-person outreach to assigned and referred Members, as cases are assigned, to determine whether they wish to enroll in CP services. Use Motivational Interviewing approach and other established engagement strategies to help Members engage.
2. Assist CCM in development of Comprehensive Assessment and Care Team for each Member, supporting the care planning process.
3. Provide peer recovery support to persons served. This includes willingness to share his/her own recovery story in intentional ways for the purpose of connection building, resource sharing, education, etc.
4. Provide care coordination among providers, according to the Care Plan and Member's wishes.
5. Provide logistical and practical support to Member in accessing services and meeting needs.
6. Provide wellness resources, including training and assistance with activities, for Members.
7. Maintain regular contact with Members, in a manner and at a frequency that is consistent with the Care Plan and the Members' preferences and expectations.
8. Make referrals and linkages to appropriate services along the continuum of care, consistent with the Care Plan.
9. Assist members (and families, as appropriate) with system navigation.
10. Provide peer support to Members in crisis, as appropriate.
11. Be available to work flexible schedule which may include evening and weekend work, as required by the needs of Members receiving services.
12. Work collaboratively with all members of Care Teams and CP teams (CCMs, CCs, Nurses).
13. Maintain complete, accurate and timely records.
14. Represent and advocate a recovery perspective in staff settings including team meetings. Promote and reinforce easy to understand recovery-oriented language.
15. Complete required documentation including maintaining neat, accurate, and timely records in accordance with agency policies and procedures along with all regulatory bodies.
16. Attend agency wide Peer Staff support meetings.
17. Participate in agency-wide and inter-agency meetings, required in-services, trainings and

committees as possible to build skills and support further integration of peer and recovery values into the organizational culture.
18. When required, attend trainings relevant to care coordination, recovery advocacy and peer support.
19. Participate actively in regular individual and group supervision and staff meetings.
20. Comply with all applicable agency clinical and administrative policies, protocols and procedures.
21. Perform other duties as assigned by supervisor.

QUALIFICATIONS: Lived experience as someone served by the mental health/addiction treatment service system and a willingness to share knowledge and experience of recovery. High school diploma and minimum of one year of sustained recovery required. Completion (or willingness to complete) the Massachusetts Certified Peer Specialist and/or the Recovery Coach Academy training is strongly preferred. Must be able to work in both community and clinical settings, relate well to a range of individuals, and promote a philosophy of recovery. Will possess strong interpersonal skills, including patience and a nonjudgmental approach. Will have ability to adapt to changing needs and responsibilities and personal resiliency in high-stress, 'crisis' situations. Will be able to document activities in a manner that meets agency requirements. Computer proficiency required including ability to work with email, electronic health record and word processing software. MA driver's license and reliable transportation required.

JOB DESCRIPTION

TITLE: CP WELLNESS COORDINATOR

PURPOSE: This position is responsible for CP staff and enrolled Members to understand and access appropriate resources, information and activities to support physical and emotional well-being among enrolled Members. The Wellness Coordinator will be trained in In SHAPE and/or other evidence-based wellness curricula; will provide in-service training and coaching of CP staff (CCMs, CCs, Peers) regarding wellness resources and strategies that are of benefit to Members with SMI and/or SUD; will provide individual and group coaching to Members as assigned.

LINE OF RESPONSIBILITY: The CP WELLNESS COORDINATOR reports to the CP Director or his/her designee.

ESSENTIAL RESPONSIBILITIES:
1. Provides in-service training and coaching for CP staff regarding wellness resources.
2. Conducts evidence-based wellness program (e.g., In SHAPE) for enrolled Members.
3. Provides education, support and resources for enrolled Members to enhance their physical and emotional well-being.
4. Works collaboratively with Care Teams and Members to design and support individual member plans.
5. Provides fitness training, monitoring and continuing reassessment of exercise, nutrition and healthcare commitments.
6. Helps members maintain focus on personal goals.

7. Encourages member participation and movement along the continuum of wellness related lifestyle changes.
8. Administers fitness assessments as needed and records data.
9. Helps plan and facilitate quarterly celebration/ recognition events for participants.
10. Assists in facilitation of team building activities.
11. Provides instruction and facilitation for group activities.
12. Assists in training interns and volunteer wellness mentors.
13. Provides supervision of interns and volunteer mentors.
14. Maintain complete, accurate and timely records.
15. Participate in all in-service training and staff meetings as required.
16. Participate in all scheduled individual and group supervision.
17. Follow agency policies and procedures.
18. Perform all other duties as assigned.
19. Comply with all applicable agency policies and procedures, including clinical and administrative protocols.

QUALIFICATIONS: Personal Trainer Certification and Bachelor's Degree in Health Science, Social Work, Rehabilitation, Psychology, Health Promotion or related field preferred. Demonstrated interpersonal/ relationship building skills, experience working collaboratively with one or more individuals to help accomplish a goal or behavior change, and demonstrated organizational skills. Demonstrated ability to provide effective training and coaching. Good listening skills, nonjudgmental ability to foster self-sufficiency. Ability to establish trusting relationships through compassion, empathy and insight. Capacity to be an effective member of a team. Demonstrated sensitivity to the needs and perspectives of people from diverse cultural or linguistic backgrounds. Computer proficiency required including ability to work with email, electronic health record and word processing software. Possesses experience and or training in motivational interviewing and motivational strategy building; is physically active, readily identifies and believes in the holistic benefits of good physical and mental health. Must also demonstrate a commitment to decreased health disparity and social stigma for individuals with BH disorders. Must be able to work independently and follow through with projects as well as be an effective member of a team. Must possess valid driver's license and reliable transportation.

JOB DESCRIPTION

TITLE: CP ADMINISTRATIVE ASSISTANT

PURPOSE: The Administrative Assistant is responsible for clerical duties and logistical support to the CP program.

LINE OF RESPONSIBILITY: The Administrative Assistant reports to the CP Director.

ESSENTIAL RESPONSIBILITIES:
1. Assist CP management team with document preparation and report compilation.
2. Make copies, maintain electronic and paper files of program policies and procedures, reports, rosters and the like. Distribute documents at the direction of CP managers.

3. Maintain schedules of regular team and staff meetings; provide logistical support to meetings (scheduling rooms, securing equipment, beverages, preparing and distributing documents, etc.)
4. Respond to customer service issues, follow up customer service issues, and ensure customer issues are professionally resolved in a timely manner.
5. Greet and direct visitors to waiting area. Ensure proper person or department is notified in a timely manner upon a visitor's arrival and monitor to ensure visitor receives a response.
6. Prepare routine correspondence for CP Director.
7. Schedule meetings for CP Director.
8. Conduct reminder calls/send emails for meetings and events as needed.
9. Provide general office administrative support, including stocking of all forms, filing all information using proper office procedures, and maintaining an organized front office and reception area.
10. Perform other duties as assigned.

QUALIFICATIONS: High School diploma or equivalent experience with demonstrated reception, typing, word processing and office skills. Good listening skills, ability to establish trusting relationships through compassion, empathy and insight. Must be an effective member of a team and show demonstrated sensitivity to the needs of families from diverse cultural and linguistic backgrounds. Appreciation of confidentiality and Member privacy, with capacity for discretion and diplomacy. Must possess excellent organizational and interpersonal skills, be detail orientated, and possess the ability to handle situations in a professional customer-service oriented manner at all times with clients, staff and external stakeholders. Computer proficiency required including ability to work with email, electronic health record and word processing software.

7.3.F. IMPLEMENTATION PLAN AND TIMELINE

Note: Because the go live date has been pushed out, extending the Prep Period, some of these activities, such as staff recruitment, may start slightly later than originally anticipated.

Preparation Period			
Month One	***Key Action Steps***	***Person Responsible***	***Timeframe***
Convene Implementation Steering Committee (ISC)	ISC will include CEO, COO, VP-HR, HR manager, AVP-Operations; led by VP-Strategic Dev't & VP-Community Services At initial meeting, ISC will review implementation plan and revise if needed	Deborah Ekstrom (DE) & Sandi Walters (SW) (VPs co-leading ISC)	Within 3 business days of award announcement ISC will meet bi-weekly or as needed during Prep Period
Begin recruitment	Post positions for all managers slated to be on board at start date	SW & Pam Powers (PP) (HR manager)	CP Director position posted w/in 5 days of award; Others w/in 10 days
Develop specific site plan for each awarded service area	IT upgrades, additions; plant changes (e.g., renovation); telephone & internet upgrades	Joanne Jackson (JJ) (AVP-Operations)	Complete w/in 45 days
Develop requisition plan	Establish requisition spec's & schedule for IT, telephone, equipment & furnishings	JJ, IT Director, Purchasing Agent	Complete w/in 45 days
Develop Credible (EHR) plan for start-up	Identify status of necessary system enhancements & refinements	SW & Business Systems team	Complete w/in 30 days
Establish Policies/Procedures committee	Identify P/Ps needed for CP in addition to established P/Ps; Include all P/Ps in Contract	Karin Jeffers (KJ) (CEO), SW and appointees TBD by CEO	Appointed w/in 14 days
Begin reviewing HR applicants	Screen, schedule for interviews	PP, SW, DE	ongoing
Finalize subcontract w/ Behavioral Health Network (BHN)	Finalize practices for subcontracting; negotiate final language	KJ, DE, BHN	End of month one
Begin outreach to ACOs/MCOs	Meet with designated leaders of ACOs/MCOs in all awarded service areas Begin development of agreements, based on EHS guidelines	KJ, DE, SW; include BHN (subcontractor) as appropriate	ongoing
Month Two			
Hire CP Director (CP Dir)	CP Dir on-boarded asap; joins ISC and P/P committee; joins recruitment process to hire staff	KJ, DE, SW select CP Dir	By end of Month Two

Begin to hire other managers	Screen, interview, select	CP Dir, SW, w/ input from DE & KJ prn	ongoing
Begin recruitment of CAB	Solicit eligible members	KJ, SW	By mid-month two
Begin recruitment of non-management staff	Post positions for all remaining staff slated to be on board at start date	PP & CP Dir (w/ SW &DE prn)	By mid-month two
Implement site changes	Per plan	JJ & operations team	ongoing
Test Credible revisions	Per plan	SW, CP Dir & Business Systems team	ongoing
Convene CQI Exec Committee	Review QI requirements for project; develop program-specific plan	Ariane Krumholz (AK), QI Director	By end of month two
Develop marketing materials customized for different stakeholders (e.g., members, referral partners)	Identify all marketing products needed Design & produce them	Dir of Marketing & DE with review by KJ, SW, CP Dir	By end of month two
Continue negotiations with ACO/MCOs	Draft agreements; identify ongoing contacts for various functions	KJ, DE, SW	By end of month two
ISC reviews status of all prep sub-systems and activities	Revise or take corrective action as necessary ISC reviews revisions of P/Ps	SW, DE, CP Dir convene	Mid-month two By end of month two
Month Three	***Key Action Steps***	***Person Responsible***	***Timeframe***
Finalize training plan	Review all curricula, identify instructors Establish training schedule	Melody Arsenault (MA) (VP-HR), SW, CP Dir MA	By mid-month three
Onboard CP managers	Finalize hiring; provide orientation & manager in-service training	PP, CP Dir, SW, DE	By end of month three
Finalize CAB membership	Provide orientation material to CAB members	SW, DE	By end of month three
Hire other staff	Screen, interview, select	PP, CP Dir, new managers, SW, DE	ongoing
Complete site changes	All space for start-up staff furnished, equipped and made fully functional	JJ & operations team	By end of month three
Review QI plan for CP	Develop data collection, monitoring & reporting workflows	AK & CP Dir	By end of month three
Finalize ACO/MCO arrangements	Execute agreements Submit to EHS for approval Establish regular meeting schedule and communication channels	KJ, DE, SW; include BHN as appropriate	By end of month three

Test Credible revisions	Per plan	SW, CP Dir & Business Systems team	ongoing
Receive client data from Mass Health (test or preliminary)	Ensure capacity to receive client assignment data in format it will be sent Evaluate & establish internal process for analyzing & managing data received	DE, JJ, IT Director, Business Systems team	When it becomes available
ISC reviews status of all prep sub-systems and activities	Revise or take corrective action as necessary	SW, DE, CP Dir convene	Mid-month three
Develop Continuity of Operations Plan (COOP)	Review existing CSO plans, adapt as needed for CP program	Exec team, led by DE	End of month three
Month Four	***Key Action Steps***	***Person Responsible***	***Timeframe***
Onboard remaining staff to be in place at start-up	Finalize hiring, provide orientation	PP, CP Dir, new supervisors	May continue into month five
Conduct in-service training for all CP staff (on all topics identified in proposal)	Deliver training per plan	Managed by HR team & CP Dir	Will continue into month five
Conduct first CAB meeting	Introduction of members to each other and to key staff	DE staff; KJ, SW, CP Dir to attend	By end of month four
Outreach to community referral partners	Provide information about CP services, contacts Ensure our understanding of their services, availability, eligibility req'ts, referral process	SW, CP Dir	ongoing
Finalize Credible revisions	Test with super-users	Business Systems team	By end of month four
Receive financial transmission spec's from Mass Health	Ensure capacity to receive payments & explanation of payments in format they will be sent Evaluate & establish internal process for analyzing & managing data received	CFO, Staff Accountant, DE, Business Systems team	When it becomes available
Receive/review reporting requirements from Mass Health	Develop plan for creating/producing all required reports	DE, CP Dir, Business Systems team	When spec's become available
ISC reviews status of all prep sub-systems and activities	Revise or take corrective action as necessary	SW, DE, CP Dir convene	Mid-month four
Month Five	***Key Action Steps***	***Person Responsible***	***Timeframe***
Onboard remaining staff to be in place at start-up	Finalize hiring, provide orientation	PP, CP Dir, new supervisors	By mid-month five
Complete initial round of in-service training for all CP staff (on all topics identified in proposal)	Deliver training per plan	Managed by HR team & CP Dir	By end of month five

Begin planning for members whose data is sent by Mass Health *OR* begin operations using test client data	Initial or simulated operation by all staff, to ensure appropriate workflows and operational understanding by staff	CP Director & supervisors	By mid-month five
Continue outreach to referral partners	Provide information about CP services, contacts Ensure our understanding of their services, availability, eligibility req'ts, referral process	SW, CP Dir	ongoing
Conduct pre-start up check-in meetings with ACO/MCOs	Confirm mutual expectations about operational issues; resolve outstanding issues	KJ, DE, SW, CP Dir; include BHN as appropriate	Before last week of month five
ISC reviews status of all prep sub-systems and activities	Revise or take corrective action as necessary	SW, DE, CP Dir convene	Mid-month five

Note: Year One activities have been adjusted to reflect 7-month period, rather than 9-month period.

Year One	***Key Action Steps***	***Person Responsible***	***Timeframe***
Activities that recur each quarter throughout Y-1:			
1. Meeting with ACO/MCOs 2. Group Meeting with Referral Partners (modeled on CSA SoC meetings) 3. Executive Mtg with BHN 4. CAB meeting 5. Internal review of metrics (monthly) 6. CQI Exec team review of QI metrics, reporting 7. Report submission to Mass Health (as required)	Agendas for all these meetings include standing items and ad hoc items, responsive to current issues	1. SW, DE, CP Dir 2. CP Dir (SW prn) 3. KJ, DE, SW, CP Dir 4. CP Dir 5. Executive team & CP Dir 6. AK, CP Director 7. CP Director, w/ support prn	All these activities will have a regular quarterly (or monthly) schedule, TBD Per contract requirements
Activities specific to Qtr 1	***Key Action Steps***	***Person Responsible***	***Timeframe***
Weekly review of operations	Identify workflow issues, technical issues, problems & promising practices Develop action plans to address issues/problems Review progress on plans	CP Management team, with SW and/or DE prn CP Mgt team, with others prn	Regular meeting TBD—e.g. Friday AM Identified issues are triaged & action planning scheduled
Bi-weekly calls w/ ACO & MCO contacts	Review any outstanding issues—assignments, clinical issues that have not been resolved through regular channels, etc.	CP Director, with support prn	Regular time TBD
Bi-weekly review of metrics	Identify actual v. planned results; analyze variance; create action plan to address if needed	CP Dir, SW, DE	Regular meeting TBD—e.g. Monday AM

Bi-weekly calls with BHN contact; reduce frequency, if appropriate	Review activities; address concerns	CP Dir, BHN designee	Weekly time TBD

Bi-monthly in-service training	Provide scheduled training for new hires, who we expect to onboard in cohorts	Managed by HR team, with designated trainers	Schedule TBD
Activities specific to Qtr 2 & December	***Key Action Steps***	***Person Responsible***	***Timeframe***
Weekly review of operations Reduce frequency to bi-weekly if/when operations are stabilized to make weekly meetings unnecessary	Identify workflow issues, technical issues, problems & promising practices Develop action plans to address issues/problems Review progress on plans	CP Management team, with SW and/or DE prn CP Mgt team, with others prn	Regular meeting TBD—e.g. Friday AM Identified issues triaged & action planning scheduled
Weekly calls w/ ACO & MCO contacts Reduce frequency to bi-weekly if/when operations are stabilized to make weekly meetings unnecessary	Review any outstanding issues—assignments, clinical issues that have not been resolved through regular channels, etc.	CP Director, with support prn	Weekly time TBD
Weekly review of metrics	Identify actual v. planned results; analyze variance; create action plan to address if needed	CP Dir, SW, DE	Regular meeting TBD—e.g. Monday AM
Weekly calls with BHN contact Reduce frequency to bi-weekly if volume is low & there are few/no issues	Review activities; address concerns	CP Dir, BHN designee	Weekly time TBD
Bi-monthly in-service training	Provide scheduled training for new hires, who we expect to onboard in cohorts	Managed by HR team, with designated trainers	Schedule TBD
Begin prep of year-end reports	Identify all necessary internal & external reports; develop specific schedule & assignments	CP Dir, SW, DE w/ AK, Business Systems team	By end of month 7
Year Two	***Key Action Steps***	***Person Responsible***	***Timeframe***
Activities that recur each quarter/month/week throughout Year Two:			
1. Meeting with ACO/MCOs 2. Group Meeting with Referral Partners 3. Executive Mtg with BHN	Agendas for all these meetings include standing items and ad hoc items, responsive to current issues	1. SW, DE, CP Dir 2. CP Dir (SW prn) 3. KJ, DE, SW, CP Dir	All these activities will have a regular quarterly (or

4. CAB meeting 5. Internal review of metrics (monthly) 6. CQI Exec team review of QI metrics, reporting 7. Report submission to Mass Health (as required)		4. CP Dir 5. Executive team & CP Dir 6. AK, CP Director 7. CP Director, w/ support prn	monthly) schedule, TBD Per contract requirements
8. Monthly review of operations	Identify workflow issues, technical issues, problems & promising practices Develop action plans to address issues/problems Review progress on plans	CP Management team, with SW and/or DE prn CP Mgt team, with others prn	Regular meeting TBD Identified issues are triaged & action planning scheduled
9. Bi-weekly review of metrics	Identify actual v. planned results; analyze variance; create action plan to address if needed	CP Dir, SW, DE	Regular meeting TBD
Activities specific to Qtr 1	***Key Action Steps***	***Person Responsible***	***Timeframe***
Complete annual reports for Year One	Prepare & submit all required internal & external reports	CP Dir, SW, DE w/ support of Exec team & Bus Systems team	Per contract requirements
Review caseloads with ACOs	Assess whether cap on "slots" is close; develop plan re referrals appropriately	CP Dir, w/ SW, DE & supervisors prn	By end of quarter
Monthly calls w/ ACO & MCO contacts	Review any outstanding issues—assignments, clinical issues that have not been resolved through regular channels, etc.	CP Director, with support prn	Regular time TBD
Bi-weekly calls with BHN contact	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
Bi-monthly in-service training	Provide scheduled training for new hires, who we expect to onboard in cohorts	Managed by HR team, with designated trainers	Schedule TBD
Activities specific to Qtr 2	***Key Action Steps***	***Person Responsible***	***Timeframe***
Bi-monthly in-service training; as staffing gets to scale, reduce to quarterly or prn	Provide scheduled training for new hires; refreshers and new information or practices for all staff	Managed by HR team, with designated trainers	Schedule TBD
Monthly calls with BHN contact; if stabilized, these calls can become prn; if not, continue monthly	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
Prepare mid-year reports	Ensure Mass Health reporting requirements are on track	CP Dir, w/ support of SW, DE, Analyst	By end of Qtr 2
Review caseloads with ACOs	Assess whether cap on "slots" is close; develop plan re referrals appropriately	CP Dir, w/ SW, DE & supervisors prn	By end of quarter
Activities specific to Qtr 3	***Key Action Steps***	***Person Responsible***	***Timeframe***

Review caseloads with ACOs	Assess whether cap on "slots" is close; develop plan re referrals appropriately	CP Dir, w/ SW, DE & supervisors prn	By end of quarter
Bi-monthly in-service training; as staffing gets to scale, reduce to quarterly or prn	Provide scheduled training for new hires; refreshers and new information or practices for all staff	Managed by HR team, with designated trainers	Schedule TBD
Monthly calls with BHN contact; if stabilized, these calls can become prn; if not, continue monthly	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
Activities specific to Qtr 4	***Key Action Steps***	***Person Responsible***	***Timeframe***
In-service training	Provide scheduled training for new hires; refreshers and new information or practices for all staff	Managed by HR team, with designated trainers	Schedule TBD
Calls with BHN contact	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
Review caseloads with ACOs; if process is stabilized, calls may become prn; if not, continue quarterly	Assess whether cap on "slots" is close; develop plan re referrals appropriately	CP Dir, w/ SW, DE & supervisors prn	By end of quarter
Begin prep of year-end reports	Review readiness status of all necessary internal & external reports; develop specific schedule & assignments	CP Dir, SW, DE w/ AK, Business Systems team	By end of month 11
Year Three - ***by year three, we will be operating at scale and many activities will be routinized***	***Key Action Steps***	***Person Responsible***	***Timeframe***
Activities that recur each quarter/month/week throughout Year Three:			
1. Meeting with ACO/MCOs 2. Group Meeting with Referral Partners 3. Executive Mtg with BHN 4. CAB meeting 5. Internal review of metrics (monthly) 6. CQI Exec team review of QI metrics, reporting 7. Report submission to Mass Health (as required)	ACO/MCO agendas will explicitly address sustainability plans Agendas for all these meetings include standing items and ad hoc items, responsive to current issues	1. SW, DE, CP Dir 2. CP Dir (SW prn) 3. KJ, DE, SW, CP Dir 4. CP Dir 5. Executive team & CP Dir 6. AK, CP Director 7. CP Director, w/ support prn	All these activities will have a regular quarterly (or monthly) schedule, TBD Per contract requirements
8. Monthly review of operations	Identify workflow issues, technical issues, problems & promising practices	CP Management team, with SW and/or DE prn	Regular meeting TBD

	Develop action plans to address issues/problems Review progress on plans	CP Mgt team, with others prn	Identified issues are triaged & action planning scheduled
9. Monthly review of metrics	Identify actual v. planned results; analyze variance; create action plan to address if needed	CP Dir, SW	Regular meeting TBD
Activities specific to Qtr 1:	***Key Action Steps***	***Person Responsible***	***Timeframe***
Complete annual reports for Year Two	Prepare & submit all required internal & external reports	CP Dir, SW, DE w/ support of Exec team & Bus Systems team	Per contract requirements
Review caseloads with ACOs	Assess whether cap on "slots" is close; develop plan re referrals appropriately	CP Dir, w/ SW, DE & supervisors prn	By end of quarter
Monthly calls w/ ACO & MCO contacts	Review any outstanding issues—assignments, clinical issues that have not been resolved through regular channels, etc.	CP Director, with support prn	Regular time TBD
Calls with BHN contact	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
In-service training	Provide scheduled training for new hires; refreshers and new information or practices for all staff	Managed by HR team, with designated trainers	Schedule TBD
Activities specific to Qtr 2:	***Key Action Steps***	***Person Responsible***	***Timeframe***
Monthly calls w/ ACO & MCO contacts	Review any outstanding issues—assignments, clinical issues that have not been resolved through regular channels, etc.	CP Director, with support prn	Regular time TBD
Calls with BHN contact	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
In-service training	Provide scheduled training for new hires; refreshers and new information or practices for all staff	Managed by HR team, with designated trainers	Schedule TBD
Prepare mid-year reports	Ensure Mass Health reporting requirements are on track	CP Dir, w/ support of SW, DE, Analyst	By end of Qtr 2
Review status of Year three Mass Health quality metrics	Data analysis, corrective action planned as necessary	CP Dir, w/ support of SW, DE, Analyst	By end of Qtr 2
Activities specific to Qtr 3:	***Key Action Steps***	***Person Responsible***	***Timeframe***
Monthly calls w/ ACO & MCO contacts	Review any outstanding issues—assignments, clinical issues that have not been resolved through	CP Director, with support prn	Regular time TBD

	regular channels, etc.		
Calls with BHN contact	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
In-service training	Provide scheduled training for new hires; refreshers and new information or practices for all staff	Managed by HR team, with designated trainers	Schedule TBD
Review status of Year three Mass Health quality metrics	Data analysis, corrective action planned as necessary	CP Dir, w/ support of SW, DE, Analyst	By end of Qtr 3
Activities specific to Qtr 4:	***Key Action Steps***	***Person Responsible***	***Timeframe***
Monthly calls w/ ACO & MCO contacts	Review any outstanding issues—assignments, clinical issues that have not been resolved through regular channels, etc.	CP Director, with support prn	Regular time TBD
Calls with BHN contact	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
In-service training	Provide scheduled training for new hires; refreshers and new information or practices for all staff	Managed by HR team, with designated trainers	Schedule TBD
Begin prep of year-end reports	Review readiness status of all necessary internal & external reports; develop specific schedule & assignments	CP Dir, SW, w/ AK, Business Systems team	By end of month 11
Year Four	***Key Action Steps***	***Person Responsible***	***Timeframe***
Activities that recur each quarter/month/week throughout Year Four:			
1. Meeting with ACO/MCOs 2. Group Meeting with Referral Partners 3. Executive Mtg with BHN 4. CAB meeting 5. Internal review of metrics (monthly) 6. CQI Exec team review of QI metrics, reporting 7. Report submission to Mass Health (as required)	ACO/MCO agendas will explicitly address sustainability plans Agendas for all these meetings include standing items and ad hoc items, responsive to current issues	1. SW, DE, CP Dir 2. CP Dir (SW prn) 3. KJ, DE, SW, CP Dir 4. CP Dir 5. Executive team & CP Dir 6. AK, CP Director 7. CP Director, w/ support prn	All these activities will have a regular quarterly (or monthly) schedule, TBD Per contract requirements
8. Monthly review of operations	Identify workflow issues, technical issues, problems & promising practices Develop action plans to address issues/problems Review progress on plans	CP Management team, with SW and/or DE prn CP Mgt team, with others prn	Regular meeting TBD Identified issues are triaged & action planning scheduled
9. Monthly review of metrics	Identify actual v. planned	CP Dir, SW	Regular meeting

	results; analyze variance; create action plan to address if needed		TBD
Activities specific to Qtr 1:	***Key Action Steps***	***Person Responsible***	***Timeframe***
Complete annual reports for Year Three	Prepare & submit all required internal & external reports	CP Dir, SW, DE w/ support of Exec team & Bus Systems team	Per contract requirements
Monthly calls w/ ACO & MCO contacts	Review any outstanding issues—assignments, clinical issues that have not been resolved through regular channels, etc.	CP Director, with support prn	Regular time TBD
Calls with BHN contact	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
In-service training	Provide scheduled training for new hires; refreshers and new information or practices for all staff	Managed by HR team, with designated trainers	Schedule TBD
Activities specific to Qtr 2:	***Key Action Steps***	***Person Responsible***	***Timeframe***
Monthly calls w/ ACO & MCO contacts	Review any outstanding issues—assignments, clinical issues that have not been resolved through regular channels, etc.	CP Director, with support prn	Regular time TBD
Calls with BHN contact	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
In-service training	Provide scheduled training for new hires; refreshers and new information or practices for all staff	Managed by HR team, with designated trainers	Schedule TBD
Prepare mid-year reports	Ensure Mass Health reporting requirements are on track	CP Dir, w/ support of SW, DE, Analyst	By end of Qtr 2
Review status of Year four Mass Health quality metrics	Data analysis, corrective action planned as necessary	CP Dir, w/ support of SW, DE, Analyst	By end of Qtr 2
Activities specific to Qtr 3:	***Key Action Steps***	***Person Responsible***	***Timeframe***
Monthly calls w/ ACO & MCO contacts	Review any outstanding issues—assignments, clinical issues that have not been resolved through regular channels, etc.	CP Director, with support prn	Regular time TBD
Calls with BHN contact	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
In-service training	Provide scheduled training for new hires; refreshers and new information or practices for all staff	Managed by HR team, with designated trainers	Schedule TBD
Review status of Year four Mass Health quality metrics	Data analysis, corrective action planned as necessary	CP Dir, w/ support of SW, DE, Analyst	By end of Qtr 3
Activities specific to Qtr 4:	***Key Action Steps***	***Person Responsible***	***Timeframe***
Monthly calls w/ ACO & MCO contacts	Review any outstanding issues—assignments, clinical issues that have not been resolved through	CP Director, with support prn	Regular time TBD

	regular channels, etc.		
Calls with BHN contact	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
In-service training	Provide scheduled training for new hires; refreshers and new information or practices for all staff	Managed by HR team, with designated trainers	Schedule TBD
Begin prep of year-end reports	Review readiness status of all necessary internal & external reports; develop specific schedule & assignments	CP Dir, SW, w/ AK, Business Systems team	By end of month 11
Year Five	***Key Action Steps***	***Person Responsible***	***Timeframe***
Activities that recur each quarter/month/week throughout Year Five:			
1. Meeting with ACO/MCOs 2. Group Meeting with Referral Partners 3. Executive Mtg with BHN 4. CAB meeting 5. Internal review of metrics (monthly) 6. CQI Exec team review of QI metrics, reporting 7. Report submission to Mass Health (as required)	ACO/MCO agendas will include final sustainability plans Agendas for all these meetings include standing items and ad hoc items, responsive to current issues	1. SW, DE, CP Dir 2. CP Dir (SW prn) 3. KJ, DE, SW, CP Dir 4. CP Dir 5. Executive team & CP Dir 6. AK, CP Director 7. CP Director, w/ support prn	All these activities will have a regular quarterly (or monthly) schedule, TBD Per contract requirements
8. Monthly review of operations	Identify workflow issues, technical issues, problems & promising practices Develop action plans to address issues/problems Review progress on plans	CP Management team, with SW and/or DE prn CP Mgt team, with others prn	Regular meeting TBD Identified issues are triaged & action planning scheduled
9. Monthly review of metrics	Identify actual v. planned results; analyze variance; create action plan to address if needed	CP Dir, SW	Regular meeting TBD
Activities specific to Qtr 1:	***Key Action Steps***	***Person Responsible***	***Timeframe***
Complete annual reports for Year Four	Prepare & submit all required internal & external reports	CP Dir, SW, DE w/ support of Exec team & Bus Systems team	Per contract requirements
Monthly calls w/ ACO & MCO contacts	Review any outstanding issues—assignments, clinical issues that have not been resolved through regular channels, etc.	CP Director, with support prn	Regular time TBD
Calls with BHN contact	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
In-service training	Provide scheduled training for	Managed by HR team,	Schedule TBD

	new hires; refreshers and new information or practices for all staff	with designated trainers	
Activities specific to Qtr 2:	***Key Action Steps***	***Person Responsible***	***Timeframe***
Monthly calls w/ ACO & MCO contacts	Review any outstanding issues—assignments, clinical issues that have not been resolved through regular channels, etc.	CP Director, with support prn	Regular time TBD
Calls with BHN contact	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
In-service training	Provide scheduled training for new hires; refreshers and new information or practices for all staff	Managed by HR team, with designated trainers	Schedule TBD
Prepare mid-year reports	Ensure Mass Health reporting requirements are on track	CP Dir, w/ support of SW, DE, Analyst	By end of Qtr 2
Review status of Year five Mass Health quality metrics	Data analysis, corrective action planned as necessary	CP Dir, w/ support of SW, DE, Analyst	By end of Qtr 2
Activities specific to Qtr 3:	***Key Action Steps***	***Person Responsible***	***Timeframe***
Monthly calls w/ ACO & MCO contacts	Review any outstanding issues—assignments, clinical issues that have not been resolved through regular channels, etc.	CP Director, with support prn	Regular time TBD
Calls with BHN contact	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
In-service training	Provide scheduled training for new hires; refreshers and new information or practices for all staff	Managed by HR team, with designated trainers	Schedule TBD
Review status of Year five Mass Health quality metrics	Data analysis, corrective action planned as necessary	CP Dir, w/ support of SW, DE, Analyst	By end of Qtr 3
Activities specific to Qtr 4:	***Key Action Steps***	***Person Responsible***	***Timeframe***
Monthly calls w/ ACO & MCO contacts	Review any outstanding issues—assignments, clinical issues that have not been resolved through regular channels, etc.	CP Director, with support prn	Regular time TBD
Calls with BHN contact	Review activities; address concerns	CP Dir, BHN designee	Regular time TBD
In-service training	Provide scheduled training for new hires; refreshers and new information or practices for all staff	Managed by HR team, with designated trainers	Schedule TBD
Begin prep of year-end & contract end reports	Review readiness status of all necessary internal & external reports; develop specific schedule & assignments	CP Dir, SW, w/ AK, Business Systems team	By end of month 11

7.3.G. BUDGET REPORT AND BUDGET NARRATIVE

CSO's Budget report and Budget Narrative are submitted separately, using revised templates provided by Mass Health.

7.3.H. SUSTAINABILITY

While sustainability is a challenge for any non-profit organization that is highly dependent on public funding, CSO has some advantages in place:

- Our cloud-based Electronic Health Record does not require high ongoing maintenance fees. We have already completed the substantial initial investment and expect that future investments, beyond the term of the CP contract, will be small enough to be covered by ongoing program revenue.
- Our administrative infrastructure, currently undergoing improvement to state-of-the-art technology for financial and HR management, is stable and sized to sustain reasonable growth in capacity.
- We are not heavily invested in real estate, preferring to lease property to house most of our sites. This limits our need for property-related capital investment and affords greater flexibility to move or to increase/decrease square footage in a location as our needs change.

CSO's executive management has demonstrated its strategic agility to grow and adapt services with the changing healthcare landscape, growing the organization from a budget of $5 million in 2005 to $35 million in FY 2017. This growth can be attributed:

- to having sights set on the future;
- cultivating and sustaining relationships with key organizational stakeholders locally and at the state level;
- having both the framework of a strategic plan and the flexibility to quickly move on strategic opportunities that arise unexpectedly; while
- continuously, vigorously attending to the quality and continual development of services; and
- cultivating and sustaining a high quality administrative management team and infrastructure.

We anticipate that this approach will continue to serve CSO in the next five years and beyond. To get to the juncture of this competitive procurement, CSO has:

- Established itself as a core provider for all the Mass Health MCOs and BH carve-out companies in western Mass. We expect to maintain our excellent reputation for service quality and responsiveness through the delivery system reform. As the MCOs manage their own new roles and challenges, we expect to continue to be a valued partner. As paradigms shift over the course of the 5-year DSRIP program, we will work with them and other organizations in the region to plan for the post-DSRIP service system and sustaining the gains and improvements that will have been made.
- Met on multiple occasions with local representatives of ACO bidders, including the Cooley Dickinson PHO leadership; the leadership team at Valley Medical Group, a large medical practice that covers the Greenfield and Northampton service area and is the largest primary care provider for CSO patients; leaders at Bay State Health, who are

candidates to play a key role in an ACO in Greenfield; and the executive team at Heywood Health, which is the largest provider (through Athol Memorial Hospital) and likely ACO partner in the Athol service area.

- Participated extensively in Mass Health's BH CP process, contributing to the design of the program and carefully coming to an understanding of the Commonwealth's goals for the CPs.

We expect that all these efforts at relationship building and achieving shared understanding will serve CSO well over the course of what is sure to be a challenging implementation and development process. Collectively, the Commonwealth, its members, health plans, and providers have great ambitions for this endeavor and must continue to work together—recognizing our interdependence—to succeed. In the course of that process, CSO expects to remain a vital and valued partner. We will work together with other system stakeholders, as we all approach the end of the 5-year project, to develop adapted financing plans, contracts and risk-sharing arrangements that are based on our collective experience—for both better and worse.

We expect that all involved will learn a lot over the coming years and that we will use those new ideas and insights to sustain an effective system of care for our clients. We will encourage our local system partners (ACOs, MCOs, LTSS CPs, providers and consumer organizations) to meet with us (individually or collectively) regularly to work on meeting performance goals and earning performance incentives. We believe that the system will improve by having stakeholders' financial incentives be well-aligned to meet the aims of improved health care and health quality. We will seek—consistent with any standards or models developed or permitted by Mass Health—to establish financial interdependency, so that financial sustenance of the CP services is an organic transition off of the DSRIP funding stream, rather than an abrupt disruption.

7.3.I. QUALITY MANAGEMENT AND PERFORMANCE MONITORING

CSO holds that its mission can be realized through the delivery of high quality programs and services in combination with advocacy efforts within a multi-level systematic approach. Quality Assurance and Continuous Quality Improvements are essential elements of CSO's operations. To support clinical best practice and innovation, CSO has established structures and processes that cultivate continuous learning. We support an organization-wide climate where feedback is freely exchanged. Employees have a clear, shared vision of the organization's goals and values. Staff get time to inquire and reflect about what they are doing and why, as well as having access to a broad range of training and professional development options.

CSO has the capacity to collect, report, and track encounter, outcome, and quality data, including but not limited to data capturing: (1) Enrollee characteristics; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) individual outcomes. Our internal Quality Improvement process begins with the data and information we collect related to our outcome measures and targets. We perform reviews of regulatory compliance and compliance with clinical standards and develop corrective measures if needed. We administer consumer satisfaction surveys annually by program to help identify issues coming out of consumer experience. Adherence to program policy and regulatory compliance are part of ongoing

monitoring of quality. Treatment plans are reviewed regularly and charts reviewed during weekly MDT meetings. Systems to identify high-risk clients have been developed and implemented that trigger a high-risk case review, associated safety plan and updated treatment plan. In the Crisis and CCS programs, supervisors perform daily reviews of client records to check for consistency of diagnosis with presentation, clinical quality, and accuracy of records and thoroughness of documentation. We use weekly executive team meetings and department head meetings, and monthly reports to the Board of Directors meetings, consumer/staff planning committees and consumer program evaluations to evaluate our progress toward established benchmarks.

CSO has established and maintains a Qualified Patient Care Assessment Program (QPCAP) in compliance with the requirements of the regulations of the Massachusetts Board of Registration in Medicine as set forth in 243 CMR 3.00 et seq. to monitor the quality of direct care services provided by the agency, with the aim of minimizing risk of injuries and incidents to patients/clients regarding care and quality of medical services, and to make recommendations for internal quality improvement. CSO's Patient Care Assessment Committee (PCAC) reviews all incidents involving patients/clients on a quarterly basis to monitor quality of direct care services. Each incident is analyzed for overall level of risk, root cause, appropriateness of preventive and/or corrective action, and analysis of statistics for trends/patterns and making recommendations for quality improvement. Members of the PCAC are multi-disciplinary and include the following listed personnel: Medical Director, program Vice Presidents (including the VP of Community Services who oversees the BH CP program), President/CEO, Director of Quality Improvement, and Vice President of Human Resources. Documentation of corrective actions or changes to programs or processes, including assessment for effectiveness, is shared with CSO's Board of Directors on a quarterly basis.

CSO develops, implements, and maintains an effective, agency-wide data-driven continuous quality improvement (CQI) plan for clinical services, care management and care coordination. The CQI projects are clearly defined, implemented, and evaluated annually. The number and scope of distinct CQI projects conducted annually are based on the needs of the CSO population and reflect the scope, complexity and past performance of CSO services and operations. The CQI plan addresses priorities for improved quality of care and client safety, and requires all improvement activities be evaluated for effectiveness. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes, and takes actions to demonstrate improvement in CSO performance. CSO documents each CQI project implemented, the reasons for the projects, and the measurable progress achieved by the projects.

QI/QM planning, oversight and response belongs with the CEO and the Senior Management Team, and is facilitated by our Director of Quality Improvement, a dedicated position established in 2010. In early 2010, CSO management began orientation to the JURAN Method and put together program dashboards on quality and utilization indicators. These provide the discipline throughout the organization to identify quality issues, diagnose and remedy the causes, and to improve the outcomes. CSO's CQI Committee is vested with responsibility for project evaluations and progress toward established benchmarks, while the VP of Community Services holds quality and risk management responsibility for the BH Community Partner program. For quality control, chart audits are conducted by clinical teams periodically. To monitor quality benchmarks, we use bi- monthly executive team meetings, staff meetings, and quarterly reports to the Board of Directors.

CSO considers it essential to measure outcomes that are consistent with recovery-oriented care in the least restrictive setting. The BH-CP CQI Team will consist of the VP of Community Based Services and Director of Quality Improvement and CP staff. Quality management tools and outcome indicators are examined and mechanisms are built in to track the success and benefits of community-based diversion. We work with program managers and staff to reach goals developed as benchmarks for each outcome.

Fidelity to practice: When complex dynamics exist as in wraparound, a robust shared vision allows organizational members to align their practices. Training, supervision, and monitoring tools help to insure fidelity to the proven wraparound systems. CSO designs and re-designs program based on evidence-based models, evaluation studies and program outcome data. Peer observation and feedback, reflective practice and debriefing, and feedback loops based on data will help ensure fidelity as well.

We conduct "Grand Rounds" weekly where all staff are invited to attend. Senior program and clinical directors facilitate discussions and guide treatment planning coordination among direct care staff. Program staff are invited, even where they are not involved with the cases presented, as a learning vehicle. Training is comprehensive, regularly scheduled and all-inclusive of CSO personnel. New staff will have the benefit of training on the clinical issues that will tend to be prevalent in our target populations though the "Grand Rounds" process. We also use coaching as part our training and supervision processes. Research shows that fidelity improves significantly when training is accompanied by coaching.

Technological Support for QI: Data captured by Credible to be analyzed for CQI purposes will be used for population based reporting, quality indicators and registry reporting. Through the following capacities of Credible, we will gather and analyze the data starting Q1 and ongoing to establish regular quality initiatives and establish measures of success:

- Tracking of critical client/consumer information
- Consumer outcomes, including medical and BH metrics
- Seamlessly view documentation, treatment plans, ISPs, and demographic data
- Set up to prioritize integrated care, with medical history, medical records, problem lists and medication information
- Data captured is both live and historical for key factors needed to support needs of medically complex individuals, support co-occurring diagnosis, including SUD and across diverse populations
- Reporting on access benchmarks, utilization benchmarks, and clinical quality indicators (e.g.; ER utilization; cost utilization; time between intake and assessment; risk assessment for those diagnosed with major depression; risk analysis; etc).

The BH CP leadership team, together with CSO's Director of Quality Improvement, will include at least one QI initiative annually based on data collected from Credible and consumer satisfaction surveys specific to the BH CP Members and services. The annual QI initiative will address, at a minimum, the following domains:

- Quality of Life
- Chronic Disease Management
- Caregiver stress
- Community tenure, isolation and social connectedness;
- Care Coordination and Care Management activities and efficacy;
- Care transitions.

For the initial QI project during the Budget Period 1, CSO will implement the MHSIP standardized consumer satisfaction survey to glean data from Consumers about satisfaction with services, perceptions related to effectiveness of care coordination and care management activities, and general quality of life feedback. The MHSIP has four primary domains that are measured: General Satisfaction; Access; Appropriateness of Services; and Outcomes. The Director of QI will provide an analysis across all four domains, and work with the BH CP team and consumer advisory board on implementing a QI project that reflects opportunity for improvement based on the data and feedback collected.

ACO/Funder Reporting: Adherence to funder requirements, program policy and regulatory compliance are part of ongoing monitoring and assessment of quality of service activities. We perform reviews of regulatory compliance and compliance with clinical standards and contract provisions. We identify areas where we are falling short and develop corrective measures.

We gather a considerable amount of data to meet state requirements for program monitoring and performance contracting, to monitor internal performance and redesign/redirect programming where performance standards are not met and to document and support billing to MassHealth (MBHP) and other third party insurers. We have 2 full time Business System team staff dedicated to EHR and systems development to ensure regulatory and reporting compliance and functionality. We will be able to adapt our systems to report to ACO and or MassHealth on any outcomes and process measures are required.

7.3.J. COORDINATION WITH ACOS AND MCOS

CSO will vigorously market Community Partner services to ACOs/MCOs, as we have already begun to do in a preliminary way throughout the development of this system reform initiative in our five service areas. Post-award efforts will include more definitive work with ACOs and MCOs, since decisions about roles in the system will have been made by Mass Health and we will be able to begin to forge real, rather than hypothetical, working relationships. CSO will negotiate contracting with the ACO's and MCO's at the Executive Level of CSO, and then share expectations and implementation plans with key BH CP leaders. CSO is already contracted as a primary network provider of multiple levels of care across with all of the MCE's and MCO's across our service region, and holds contracts with the Hospital systems as well. We don't expect any challenges in negotiating and finalizing contracts with the ACO's or the MCO's related to the BH CP contracting. Significant energy will focus on discussions around assignment of BH CP members in our service area, and negotiating communication and bilateral expectations of the partners from Executive to front line workers. As part of our strategy, it will be important for ACO's and MCO's to understand and appreciate the value of having a community based BH CP as part of their service delivery and management umbrella.

To that end, our marketing approach will make five key points:

- Market wellness focus on preventive health and strategies that encourage patients to take care of themselves.
- Study the patient base: Conduct thorough research on the patient base, including prevalent chronic conditions, services frequently used and where most patients access care
- Communicate the benefits: High-quality, coordinated care is a benefit that is worth explaining and promoting.
- Build the marketing around solid analytics: Demonstrate our success with solid outcome data.

- Education to the ACO and MCO partners about the value and expertise of the Community Based system, and specifically the BH CP role, in achieving true behavior change among the most difficult, often highest cost, Enrolled Members.

As part of the role of ACOs to develop high value, clinically integrated provider partnerships, we expect to achieve coordinated care by using the lines of communication and coordination that increase BH integration and linkages to social services in the individual ACO model through explicit requirements in the partnership with CSO as a BH Community Partner. Where an MCO is involved, we expect to work with MCOS and ACOs to improve care delivery and to support integration of care. We expect to collaborate with the MCO in using analytics for population health management. We would expect that these will take place through regularly scheduled meetings and the development of electronic communication methods.

CSO will accept Enrollees Assigned by EOHHS, an ACO, or an MCO to the full extent of the Contractor's Capacity. CSO will notify EOHHS/ACO/MCO within one business day of the Assignment to confirm receipt of the Assignment from EOHHS/ACO /MCO. For each Assigned Enrollee, CSO shall create an Enrollee record in accordance with record keeping requirements specified in the contract. CSO will submit a "Person-Centered Treatment Plan complete" Qualifying Activities. CSO will report on disengagements and reasons for those disengagements. CSO will provide EOHHS/ACO /MCO with data on the Clinical Quality Measures and any further requested data in the requested form and format no later than ninety (90) days after receiving such request.

Our plan for managing the project is intended to maximize program continuity and coordination among those delivering services and to achieve smooth transitions for Enrollees. The management for the project will be conducted on two levels. The first is where Executive Committee ensures that program staff adhere to the timetable outlined in 7.2 Section C.3.. Executive staff will be responsible for 1) liaison with senior staff at ACOs/COs; 2) briefing the Board of Directors; 3) identifying and or responding to resources needs for the project; and 4) convening for the purpose of higher level policy analysis/planning/brokering; and 5) internal and external conflict resolution, review evaluations and other functions that require senior leadership and authority. The second level is the Project Team—program and clinical staff involved in the project—will review the accomplishments in monthly team meetings as well as leading the development of initiatives internal to their departments. Reporting and coordinating communication are the key functions of program staff.

CSO's expertise is well known to the local Community Stakeholders, medical community, and hospital systems. We work closely with all of them currently, and are encouraged by the opportunity to have better funded care coordination and partnership structures formalized through the BH CP program. Upon award, we will meet with all ACO and MCO partners in our service area to bring specific data about the services available through the BH CP for the target population. The close collaboration and bilateral subcontracting relationship with CSO and BHN on the BH CP project will provide opportunity for both agencies to meet across the region with the ACO's and MCO's to build similar structures for communication, marketing, implementation activities and quality initiatives. This collaboration will streamline management of the BH CP system for the ACO's and MCO's who will likely have multiple CP's to work with as well, and enhance the regional collaboration of the overall ACO/MCO/BH CP system.

Both CSO and BHN have a long history of engaging and collaborating with multiple MCO's and MCE's, and are confident that this success will apply to engagement with multiple

ACO's as well. We will work with all BH CP stakeholders, the ACO systems, MCO's and the State to help standardize processes as much as possible. We will mutually develop conflict resolution strategies (to be included in the negotiated contract agreement) before any potential conflict arises, to assist in working through potential differences. We will have well established executive level communication channels, and well developed policies and procedures for the program, designed to minimize and prevent conflict. We will collectively strive to achieve all quality reporting measures throughout the life of the BH CP program, while collaborating to meet total cost of care standards across the population.

Community Partner Program Budget Report

			Community Care Partners, LLC					
	Program Revenue	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
	Estimated Enrollees- Start of Period (All Enrollees)		0	2,580	4,706	5,496	5,540	
	Estimated Enrollees - End of Period (All Enrollees)		2,580	4,706	5,496	5,540	5,540	
	Estimated Enrollees - Monthly Average (excl CBFS enrollees)		1,075	2,893	3,973	4,088	4,076	
	Estimated Enrollees - Monthly Average (CBFS enrollees only)		1,141	1,467	1,464	1,464	1,464	
	Estimated Program Revenue (excl CBFS enrollees)		$ 1,354,157	$ 6,248,039	$ 8,582,401	$ 8,830,335	$ 8,804,868	$ 33,819,801
	Estimated Program Revenue (CBFS enrollees only)		$ 1,996,315	$ 4,400,814	$ 4,392,000	$ 4,392,000	$ 4,392,000	$ 19,573,129
	Total Estimated Program Revenue		**$ 3,350,472**	**$ 10,648,853**	**$ 12,974,401**	**$ 13,222,335**	**$ 13,196,868**	**$ 53,392,930**
	At- Risk Withhold Rate			0%	0%	0%	0%	
	Withhold funds			$ -	$ -	$ -	$ -	$ -
	Revenue for Operations		**$ 3,350,472**	**$ 10,648,853**	**$ 12,974,401**	**$ 13,222,335**	**$ 13,196,868**	**$ 53,392,930**
	Program Expenses	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
1	**Salary**	$ 245,269	$ 2,898,270	$ 7,388,115	$ 8,590,675	$ 8,788,362	$ 8,857,332	$ 36,768,023
2	**Fringe**	$ 58,864	$ 695,585	$ 1,773,148	$ 2,061,762	$ 2,109,207	$ 2,125,760	$ 8,824,325
	Total Personnel Costs	$ 304,133	$ 3,593,854	$ 9,161,262	$ 10,652,437	$ 10,897,569	$ 10,983,092	$ 45,592,348
3	**Training & Professional Development**	$ 2,182	$ 25,785	$ 65,730	$ 76,429	$ 78,188	$ 78,801	$ 327,116
4	**Travel**	$ 5,142	$ 60,759	$ 154,884	$ 180,095	$ 184,239	$ 185,685	$ 770,804
5	**Equipment**	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	**Supplies**	$ 1,870	$ 22,102	$ 56,340	$ 65,511	$ 67,018	$ 67,544	$ 280,385
7	**Contract Services** (consulting, professional)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	**Software licensing**	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	**Telecommunications**	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	**Occupancy** (rent, utilities, maintenance)	$ 11,611	$ 137,207	$ 349,760	$ 406,690	$ 416,049	$ 419,314	$ 1,740,630
11	**Other**	$ -	$ 15,000	$ 15,000	$ 15,000	$ 15,000	$ 15,000	$ 75,000
	Total Direct Costs	$ 324,939	$ 3,854,707	$ 9,802,977	$ 11,396,161	$ 11,658,063	$ 11,749,436	$ 48,786,283
12	**Indirect Cost/Administrative Overhead** **12.1%**	**$ 39,246**	**$ 465,576**	**$ 1,184,014**	**$ 1,376,440**	**$ 1,408,073**	**$ 1,419,109**	$ 5,892,458
	TOTAL EXPENSES	$ 364,185	$ 4,320,283	$ 10,986,990	$ 12,772,601	$ 13,066,136	$ 13,168,545	$ 54,678,741
	Surplus/Shortfall	*$ (364,185)*	*$ (969,811)*	*$ (338,137)*	*$ 201,800*	*$ 156,199*	*$ 28,323*	*$ (1,285,811)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Executive Director	$ 150,000.00	0.2	4.5	$ 11,250
Psychiatrist	$ 200,000.00	0.15	0.5	$ 1,250
Administrative Assistant	$ 50,000.00	1	1.5	$ 6,250
Intake Specialist	$ 47,500.00	1.5	0.5	$ 2,969
Customer Service	$ 47,500.00	1.5	0.5	$ 2,969
Assessment/Engagement Team Leader	$ 76,500.00	2	1	$ 12,750
Program Director/ Dir. of Care Coordination	$ 95,000.00	2.55	5	$ 100,938
Assistant Program Director	$ 87,500.00	2	2.7	$ 39,956
Care Team Leader	$ 76,500.00	7	1.5	$ 66,938
				$ -
				$ -
				$ -
Total Salary (Program Budget Line 1)		**17.9**		**$ 245,269**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 245,268.65	24%	$ 58,864
Total Fringe (Program Budget Line 2)			**$ 58,864**

Total Personnel*	**$ 304,133**

* Should align with Personnel Costs row in Program Budget

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
ongoing employee training			$ 2,182.09
Total Training and Professional Development (Program Budget Line 3)			**$ 2,182.09**

Provide a description of each Training and Professional Development line item included in the table above:

Based on the experience of the Member organizations, $546/year/FTE has been allocated to support the administration of ongoing training and professional development. This will cover the administration of ongoing training and development.

The $2,182.09 represents approximately 4 FTEs.

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
Executive Director	350	2.25	0.535	$ 421.31
Assessment/Engagement Team Leader	200	2	0.535	$ 214.00
Program Director/ Dir. of Care Coordination (2.55 FTEs, about 4.7 or 5 months)	200	12	0.535	$ 1,284.00
Assistant Program Director	200	5	0.535	$ 535.00
Care Team Leaders (7FTEs, each 1.5 months)	200	10.5	0.535	$ 1,123.50
				$ -
			Total Mileage	$ 3,577.81

Travel Expense Description	Cost
Total Mileage	$ 3,577.81
Parking and tolls	$ 1,564.19
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ 5,142.00**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

In the Prep Budget Period, the Program Directors, Assistant Program Directors and Executive Director will travel to meetings with ACOs and MCOs leaders across Eastern Massachusetts from Cape Cod to Attleboro to Lowell to Salem and across Boston. The Engagement Team Leaders and Care Team Leaders will travel to locall-based care team offices for interviews and for meetings with providers. Some staff will also attend MassHealth meetings. Travel expenses include mileage and parking costs.
Please note: There are 7 Care Team Leaders who will each work 1.5 months in the Prep budget period adding up to 10.5 months total. Program Director/ Dir. of Care Coordination is 2.55 FTEs and will be for about 4.7 or 5 months.

Row 5 - Equipment

Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost
Total Equipment (Program Budget Line 5)			

For each position listed above, provide a brief statement of the position's responsibilities:

Executive Director: responsible for the oversight and operations of EMCP. The role collaborates with the governing board and the member organizations and is responsible for all administrative and related activities including management of the human, fiscal and community resources necessary to ensure that the Community Partners program is planned and managed to the highest standards of the industry. The Executive Director represents EMCP to all external constituencies.

Psychiatrist/ Medical Director: Provides clinical supervision to care teams through case reviews and ad hoc consultations.

Administrative Assistant: supports central EMCP team and coordinates with care team staff

Intake Specialist: helps process electronic and telephonic referrals from ACOs and other providers, families or potential Enrollees, refers Enrollee to appropriate local BH CP care team for engagement.

Customer Service: takes calls from providers or Enrollees acting as first line of information; receives and processes grievances

Assessment/Engagement Team Leader: In start up phase of the program, as large numbers of Assigned Enrollees enter the EMCP program, 2 Assessment/Engagement Team Leaders will supervise dedicated Assessment/ Engagement staff.**

Program Director/ Director of Care Coordination: Bay Cove and Vinfen will each hire a Program Director to manage the Team Leaders and have overall responsibility for development of the programmatic and clinical functions of the BH CP program. Bridgewell's Director of Clinical Services will serve as Director of Care Coordination for Bridgewell's BH CP care teams.**

Assistant Program Director: for the Member organizations with larger number of Enrollees, this position will support the Program Director in supervising teams and providing project management support to get the program off the ground developing standardized processes within care teams. These positions will be hired as early as possible in March 2018 that funding allows. They will initially engage in hiring team leaders and the first care coordinators/clinical care managers. **

Care Team Leaders: The Team Leader provides clinical and programmatic oversight to a local care team. This role directly supervises Care Coordinators, Clinical Care Managers, and Recovery Support Navigators in the provision of care coordination and clinical care management. Based on projected membership volume, Bay Cove and Vinfen will each hire 3 Care Team Leaders and Bridgewell will hire 1 Care Team Leader.

** For the above positions of Engagement Team Leader, Program Director and Assistant Program Director, Vinfen and Bay Cove are each allocated 1 FTE based on membership volume. Bridgewell is allocated a portion of a Program Director that is the equivalent of all 3 above positions (Engagement Team Leader, Program Director and Assistant Program Director) based on its projected membership.

Executive Director – This role will support EMCP and BLTSSCP and is a centralized function. The role is allocated 20% to EMCP and 80% to BLTSSCP because in the prep budget period we are developing the program infrastructure and BLTSSCP has 7 organizations involved whereas EMCP has 3 organizations involved.

Intake and customer service – allocated only to EMCP, rather than to multiple Consortium Entities, because it's a centralized function;

Psychiatrist – allocated only to EMCP, rather than to multiple Consortium Entities, because it's a centralized function

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Office supplies, printing, copying, postage			$ 1,870.37
Total Supplies (Program Budget Line 6)			**$ 1,870.37**

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Based on the experience of the Member organizations existing care coordination programs, $39/month/FTE has been allocated for supplies including office supplies, printing, copying, and postage for approximately 4 FTEs.

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
Total Software Licensing (Program Budget Line 8)			

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Total Telecommunications (Program Budget Line 9)			

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent			$ 9,363.75
Utilities			$ 2,247.30
Repair and Maintenance			$ -
			$ -
			$ -
Total Occupancy (Program Budget Line 10)			**$ 11,611.05**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

The member organizations have extensive experience renting and purchasing both office and residential space in communities across Massachusetts. The members' experience is that $269.85/FTE month is an adequate amount for rent and $64.76/FTE month for utilities although rates vary across Massachusetts. In row 1, there are 34.7 FTE months in the Prep budget year. We commit to not allocating more than $25/square foot for rent.

This funding will support the three care coordination organizations to lease work space for 7 locally based care teams. The space will provide flexible work stations for care coordinators who spend the majority of their time in the community but need a place to dock for supervision, documentation, copying, printing, etc. In addition, EMCP will lease work space for the management team at a central, Boston location.

Row 11 - Other

Other Direct Expense Description	Cost
Total Other (Program Budget Line 11)	

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	**12.08%**	**$ 39,246.44**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

This administration line includes all non-direct administrative functions to support the program including human resources at each Member for recruitment, HR management and training, accounts payable, payroll, IT maintenance and support, and building/location/real estate functions. It has been an appropriate amount based on experience.

Community Partner Infrastructure Budget Report

	Community Care Partners, LLC						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
PMPM Infrastructure Rate		$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
Engaged Enrollees		2,580	2,580	4,706	5,496	5,540	
Estimated Infrastructure Funds		$ 1,805,934	$ 2,664,010	$ 2,907,563	$ 2,994,093	$ 2,611,489	**$ 12,983,089**
At- Risk Withhold Rate			25%	44%	63%	81%	
Withhold			$ 666,002	$ 1,279,328	$ 1,886,279	$ 2,115,306	**$ 5,946,915**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 1,805,934	$ 1,998,007	$ 1,628,236	$ 1,107,814	$ 496,183	**$ 7,486,174**

	Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
	Technology							
1	**IT Staffing including Fringe**	$ 21,096	$ 157,023	$ 225,799	$ 229,433	$ 233,139	$ 236,919	**$ 1,103,408**
2	**Development Adaptation of EHR and/or Care Management System**	$ -	$ 109,006	$ 108,000	$ 108,000	$ 108,000	$ 108,000	**$ 541,006**
3	**Technology for Service Delivery**	$ -	$ 47,864	$ 161,316	$ 174,155	$ 169,065	$ 169,802	**$ 722,202**
4	**Other Technology Expenses**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Technology	$ 21,096	$ 313,893	$ 495,115	$ 511,587	$ 510,204	$ 514,721	**$ 2,366,616**
	Workforce Development							
5	**Workforce Development staffing including Fringe**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
6	**Recruitment Expenses**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
7	**Training Expenses**	$ -	$ 20,000	$ -	$ -	$ -	$ -	**$ 20,000**
8	**Retention Expenses**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Workforce Development	$ -	$ 20,000	$ -	$ -	$ -	$ -	**$ 20,000**
	Business Start Up Costs							
9	**Office Equipment (PBP & BP1 only)**	$ -	$ -					**$ -**
10	**Office Furniture (PBP & BP1 only)**	$ -	$ -					**$ -**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**	$ 364,185	$ 969,811	$ 338,137	$ -			**$ 1,672,133**
	Total Business Start Up Costs	$ 364,185	$ 969,811	$ 338,137				**$ 1,672,133**
	Operational Infrastructure							
12	**Operation Staffing including Fringe**	$ 60,079	$ 472,485	$ 649,995	$ 661,689	$ 673,617	$ 686,483	**$ 3,204,347**
13	**Other Operational Expenses**	$ 2,700	$ 111,898	$ 88,200	$ 74,541	$ 65,922	$ 67,345	**$ 410,606**
	Total Operational Infrastructure	$ 62,779	$ 584,383	$ 738,195	$ 736,230	$ 739,539	$ 753,828	**$ 3,614,953**
14	**Indirect Cost/Administrative Overhead Rate**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	TOTAL INVESTMENTS	**$ 448,060**	**$ 1,888,086**	**$ 1,571,447**	**$ 1,247,817**	**$ 1,249,743**	**$ 1,268,549**	**$ 7,673,702**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Tier 2 support	$ 57,500.00	1	3.55	$ 17,013
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary			$ 17,013
	Fringe rate	24.0%	Total Fringe	$ 4,083
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 21,096**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Learning, testing, and training regarding use of the Care Coordination and Information Technology system. Preparation to train users and handle HelpDesk type questions about the systems. We will hire this person as soon as funding allows in the month of February, 2018.

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost

	A	B	C	D	E	F	G
34							
35							
36							
37							
38							
39	**Total Development and Adaptation of EHR and Care**						
40	**Management System**						
41	**(Infrastructure Budget Line 2)**						
42							
43	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
44	***contract and how the costs were determined:***						
45							
46							
47							
48							
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51							
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54							
55							
56							
57							
58	**Row 3 - Technology for Service Delivery**						
59	**Description of Expense**	**Cost**					
60							
61							
62							
63							
64							
65							
66	**Total Technology for Service Delivery**						

	A	B	C	D	E	F	G
67	**(Infrastructure Budget Line 3)**						
68							
69	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
70	***contract and how the costs were determined:***						
71							
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80							
81							
82							
83							
84							
85	**Row 4 - Other Technology Expenses**						
86	**Description of Expense**	**Cost**					
87							
88							
89							
90							
91							
92							
93	**Total Other Technology Expenses**						
94	**(Infrastructure Budget Line 4)**						
95							
96	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
97	***contract and how the costs were determined:***						
98							
99							

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 6 - Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses (Infrastructure Budget Line 6)	

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Row 7 - Training Expenses

Description of Expense	Cost
Total Training Expenses (Infrastructure Budget Line 7)	

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Row 8 - Retention Expenses

Description of Expense	Cost

	A	B	C	D	E	F	G
199							
200							
201							
202							
203							
204	**Total Retention Expenses**						
205	**(Infrastructure Budget Line 8)**						
206							
207	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms***						
208	***of the CP's contract and how the costs were determined:***						
209							
210							
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221							
222							
223	**Community Partner <u>Infrastructure</u> Budget Report - Business Start Up Costs - Prep Budget Period**						
224							
225	**Row 9 - Office Equipment**						
226	Description of Expense	Cost					
227							
228							
229							
230							

	A	B	C	D	E	F	G
231							
232							
233	**Total Office Equipment**						
234	**(Infrastructure Budget Line 9)**						
235							
236	***Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were***						
237	***determined:***						
238							
239							
240							
241							
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250							
251							
252	**Row 10 - Office Furniture**						
253	Description of Expense	Cost					
254							
255							
256							
257							
258							
259							
260	**Total Office Furniture**						
261	**(Infrastructure Budget Line 10)**						
262							
263	***Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were***						

determined:

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Director of Operations	$ 95,000.00	0.2	5.2	$ 8,190.58
Director of Quality and Analytics	$ 95,000.00	0.2	5.2	$ 8,190.58
Project Manager	$ 75,000.00	0.2	5.5	$ 6,875.00
VP - Controller	$ 128,000.00	0.06	5.5	$ 3,520.00
Budget Director	$ 85,000.00	0.03	5.5	$ 1,168.75
Director of Accounts Receivable	$ 91,250.00	0.045	5.5	$ 1,882.03
Business Analyst	$ 75,000.00	0.18	5.5	$ 6,187.50
Senior Accountant	$ 70,000.00	0.18	5.5	$ 5,775.00
Billing Coordinator	$ 40,000.00	0.3	5.5	$ 5,500.00
Manager of Business Systems	$ 84,482.00	0.03	5.5	$ 1,161.63
	Total Salary	1.425		$ 48,451.08
	Fringe rate	24.0%	Total Fringe	$ 11,628.26
			Total Program Staffing including Fringe	**$ 60,079.33**

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	A	B	C	D	E	F	G
295				**(Infrastructure Budget Line 12)**	**$ 60,079.33**		

Row 13 - Other Operational Expenses

Description of Expense	Cost
Financial software (setup, mgmt, licenses)	$ 2,700.00
Total Other Operational Expenses (Infrastructure Budget Line 13)	**$ 2,700.00**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

As part of standing up the financial system for the program, it will be necessary to license, set up, and expand the users of the software for all the payors and payees. This is more financial set up and management than IT.

	A	B	C	D	E	F	G
328							Manager of purchasing, setup in ord out program
329							
330							
331							
332							
333							
334							
335	**Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period**						
336							
337	**Row 14 - Indirect Cost/Administrative Overhead**						
338	**Indirect Cost/Administrative Overhead**	**Rate**	**Total Indirect Cost**				
339	**Total Indirect Cost/Administrative Overhead (Program Budget Line 14)**						
340							
341							
342							
343	***Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:***						
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345							
346	EMCP is choosing not to include an administrative overhead rate in the infrastructure budget for two reasons:						
347	1) EMCP is the management company for administering the BH CP program on behalf of Bay Cove, Bridgewell and Vinfen. We						
348	consider EMCP itself as administrative overhead for the BH CP program.						
349	2) In the infrastructure budget, there are costs that are not within the EMCP organization itself. For example, financial services						
350	are contracted out to Bay Cove and IT services are contracted out to Vinfen. Our assumption is that the administrative overhead						
351	rate within the program budget will cover administration of those additional services.						
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	A	B	C	D	E	F	G
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Community Partner Infrastructure Allocation Worksheet

	Community Care Partners, LLC						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 1,805,934	$ 1,998,007	$ 1,628,236	$ 1,107,814	$ 496,183	$ 7,486,174
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
EMCP	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bay Cove	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bridgewell	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Vinfen	$ 21,096	$ 313,893	$ 495,115	$ 511,587	$ 510,204	$ 514,721	$ 2,366,616
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ 21,096	$ 313,893	$ 495,115	$ 511,587	$ 510,204	$ 514,721	$ 2,366,616
Workforce Development							
EMCP	$ -	$ 20,000	$ -	$ -	$ -	$ -	$ 20,000
Bay Cove	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bridgewell	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Vinfen	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ -	$ 20,000	$ -	$ -	$ -	$ -	$ 20,000
Business Start Up Costs							
EMCP	$ 16,738	$ 243,085	$ 341,571	$ -	$ -	$ -	$ 601,394
Bay Cove	$ 153,350	$ 248,167	$ 57,073	$ 59,357	$ 44,050	$ -	$ 561,996
Bridgewell	$ 40,747	$ 63,007	$ 13,123	$ 10,428	$ 7,295	$ -	$ 134,599
Vinfen	$ 153,350	$ 290,826	$ 69,805	$ 70,215	$ 48,655	$ -	$ 632,851
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ 364,185	$ 845,085	$ 481,572	$ 140,000	$ 100,000	$ -	$ 1,930,842
Operational Infrastructure							
EMCP	$ 27,445	$ 270,963	$ 444,127	$ 436,388	$ 433,795	$ 442,049	$ 2,054,767
Bay Cove	$ 35,334	$ 283,420	$ 289,068	$ 294,842	$ 300,744	$ 306,779	$ 1,510,186
Bridgewell	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Vinfen	$ -	$ 30,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 50,000
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ 62,779	$ 584,383	$ 738,195	$ 736,230	$ 739,539	$ 753,828	$ 3,614,953
TOTAL INVESTMENTS	$ 448,060	$ 1,763,360	$ 1,714,882	$ 1,387,817	$ 1,349,743	$ 1,268,549	$ 7,932,411

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Care Coordination Information System	Procure, configure and implement a Care Coord. Info. System	07/01/17	12/31/18	Release RFP to care coordination system vendors, select and contract with 1 vendor, develop requirements for initial configuration of system	Contract with care coordination sytem vendor, implementation plan agreed to Please specify milestone for implementation plan. Who needs to agree or approve it?			Finalize design for care coordination platform	Design documents showing how care coordination system will be configured		
Technology												
Technology												
Technology												
Workforce Development	Development of comprehensive training curriculum and plan for delivering curriculum	Develop 13 modules of training curriculum and put in format for BHCP employees	07/01/17	05/31/18	Five of the 13 modules developed and formatted for BHCP employees; training implementation plan developed	Sampling of the completed modules, implementation plan document			All 13 modules developed and formatted for BHCP employees	Sampling of the 13 developed modules		
Workforce Development	Fill key EMCP management team and care team leader positions	Four key EMCP management positions, Directors of Care Coordination and five care team leader positions filled	10/01/17	05/31/18	Key EMCP management team positions and member organization positions are filled	EMCP Executive Director, Project Manager and Directors of Care Coordination hired			Additional key EMCP management team positions and care team leaders are filled	5 care team leaders hired/appointed; EMCP Director of Operations and EMCP Dir. of Quality and Analytics hired		
Workforce Development												
Workforce Development												
Business Start Up Costs	Care Coordination contracts	Develop contracts with each of the 3 organizations providing local BH CP care teams Please clarify: are you referring to Vinfen, Bay Cove, and Bridgewell?	07/01/17	04/01/18	Contracts developed with each of the 3 organizations providing BHCP care team services that include program specifications, payment terms	Executed contracts						
Business Start Up Costs	Financial systems	Develop key financial systems including chart of accounts, financial report requirements, configuration of accounting software. Investments related to this project are budgeted inder Operational Infrastucture. Should be moved to Ops below.	09/01/17	05/31/18	Business Analyst hired, chart of accounts established, financial reporting specifications developed, uniform fiscal reporting procedures established.	Business Analyst hired, chart of accounts established, sample financial reporting specifications			Hire and train Billing Coordinator, test accounting software and fiscal reporting process. Complete documentation of billing procedures. Develop and document payment procedures to partner entities.	Billing Coordinator hired, sample documentation of billing and payment procedures		
Business Start Up Costs	ACO/MCO contracting	Execute agreements with 13 ACOs and 2 MCOs	07/01/17	04/30/18	Model agreement developed and shared with ACO/MCOs inclusive of proposed documented processes Question: why draft agreement instead of executed contracts?	Draft of model ACO/MCO agreement inclusive of proposed documented processes under consideration			Agreements executed with 13 ACOs and 2 MCOs	Executed agreements		
Business Start Up Costs												
Operational Infrastructure	Development of Documented Processes	Development of 11 Documented Processes for internal planning and ACO/MCO contracting	07/01/17	04/30/18	Drafts of Documented Processes developed and under consideration Please indicate who will draft these and number of processes you plan to draft	Draft of Documented Processes developed and under consideration						
Operational Infrastructure	Referral/assignment process	Develop process for receiving referrals from MassHealth, ACOs and MCOs and distributing those to care coordination organizations	07/01/17	05/31/18	Process developed and data specifications for receipt of referrals Please specify who.	Documented workflows			Process tested with three ACO/MCOs	Documentation of test		
Operational Infrastructure												
Operational Infrastructure												

BH Community Partner - Staffing Model

Community Care Partners, LLC

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	2,580	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	4.6	*Total management oversight of BH CP*
3	Medical Director	0.15	*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs		
5	Clinical Care Managers (RN)	15.0	*Do not include FTEs listed in line 4*
6	Clinical Care Managers (LPHA)	17.0	*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders	8.3	*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff		*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	44.0	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)		*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists		
12	Administrative Support	5.3	
13			
14			
	Total FTE	94.2	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	172.0	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	9.19	*Total Care Coordinator and Clinical Care Manager FTEs divided by Total Care Coordination Supervis*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff:
All Care Coordinators and Clinical Care Managers (lines 5, 6 and 9) are supervised by Team Leaders. At this point in time, at the end of Budget Period 1 (2018), 2 of the Team Leaders will oversee special Assessment/Engagement teams that will work with the high number of Assigned Enrollees being referred to the program throughout 2018 and 2019. An estimated 21 employees (3 RN Clinical Care Managers, 7 LPHA Clinical Care Managers and 11 Health Outreach Workers) will be dedicated to engaging and assessing Assigned Enrollees in this time period.
Note: line 16 - we divided total Care Coordinators and Clinical Care Managers by the Team Leaders

7.3 A Executive Summary

Eastern Massachusetts Community Partners (EMCP) is a newly formed organization that brings together three Community-Based Organizations ("Members") to provide BH CP services to people with SMI/SUD. Each Member, on its own, is a leader both in its local communities and in its field of service. Bay Cove is one of the state's premier SUD providers with a full continuum of care for people with addictions. With blended expertise in SMI and SUD, Bay Cove has a reputable track record of meeting the most challenging needs of people with Dual Diagnoses in the Commonwealth. Bridgewell is a major outpatient mental health provider in the Northern region with four practices and is known as an innovator in SUD programs, embedding Recovery Coaches in a local hospital Emergency Department to engage people who have overdosed. Vinfen is the largest DMH contractor and CBFS provider in Massachusetts and is known for its adherence to recovery and rehabilitation based services, adoption of evidence based practices, and technology innovation. Together the Members have a presence in most communities in Eastern Massachusetts including relationships with social service providers, hospital systems, local government, police and BH providers. This local presence is the foundation for developing locally based care teams that will perform the functions of the BH CP program.

EMCP is committed to the integration of BH, medical and LTSS in order to better serve people with SMI/SUD. Evidence of this commitment is apparent in the programs launched by each Member: CBFS, One Care Health Homes, SUD Treatment Center, Young Adult Diversion and Homeless Outreach. EMCP fully supports the goals of EOHHS' proposed delivery reforms as described in EOHHS' 1115 Waiver Extension Request and the BH CP goals in particular to 1) integrate medical and BH care for people with SMI/SUD and 2) strengthen linkages to social services and LTSS. The larger MassHealth demonstration will create the necessary structure for the BH CP program to be successful by holding providers accountable for total cost of care. This shift to accountable care will encourage providers to expand their programs and resources to focus on people with SMI/SUD that has only previously occurred on a much smaller scale.

People with SMI face significant barriers to accessing health care services and to partnering with their health care providers to improve their health. The result is a higher disease burden and greater use of costly health services such as Emergency Department and inpatient. The health delivery challenges faced by people with SMI are widely recognized in the literature and illustrated in their greater disease burden: 50% more likely to be obese and twice as likely to be smokers than average. The barriers they face to accessing services and to partnering with their health care providers include: interpersonal ones such as a history of trauma and/or cognitive impairments; non-existent or poorly functioning support networks; housing instability; and stigma. In addition to these challenges, in many communities, there are gaps in certain types of BH services including outpatient mental health, day programs and crisis stabilization.

To address these challenges, EMCP will provide services in the seven domains of BH CP supports: outreach and active engagement; Comprehensive Assessment and Person-centered Treatment Planning; care coordination and care management; support for care transitions; medication reconciliation; health and wellness coaching; and connection to community and social services. Although all seven domains are important and EMCP will provide supports to address all, in the first year of the program, a key focus will be on Enrollee engagement. Many people with SMI/SUD have never been enrolled in outreach or care coordination programs before and may be hesitant to participate for all the reasons listed above. Individuals served in the DMH system have often not been engaged in managing their physical health. Without

successful Enrollee engagement, the rest of the BH CP support services cannot be of benefit to Enrollees. EMCP will create an Enrollee Engagement Library of best practices, it will be an important principle of training for Care Coordinators and Clinical Care Managers, and it will be infused throughout the Learning Collaborative that will be created. Enrollee Engagement will also be the focus of EMCP's Quality Improvement program in the first year of the program.

EMCP recognizes that to be effective, the core BH CP services must be provided in close partnerships with ACO/MCOs, the entities at risk for Total Cost of Care in the new MassHealth delivery system. As a result, EMCP will invest considerable staff resources to develop ACO collaborations to coordinate care, reduce duplication of services, and target limited resources to the right Enrollees at the right time. In service areas demanding more than one care team, teams will be organized, as much as possible, to align with not more than one or two ACO/MCOs.

EMCP will support 5,400 Enrollees when at its designed Capacity, after a 16-month ramp-up period. EMCP has developed enrollment projections that take into account estimated numbers of ACO/MCO referrals and existing clients in specific Service Areas as well as estimated participation rates. EMCP will serve all of Greater Boston and eight of the ten Service Areas in the Southern Regions and six of the nine Service Areas in the Northern Region (Haverhill, Lawrence, Lowell, Lynn, Malden, Salem).

EMCP will employ a central management team that is responsible for overall performance and contract management with EOHHS, ACO/MCOs and Member organizations. The central management team will be responsible for developing certain operational and programmatic elements of the BH CP program including training curriculum for Care teams, a regular learning collaborative for Care Coordinators, a central intake process for accepting ACO/MCO referrals and assigning them to care teams, and Consumer Advisory Boards. Each Member will develop locally based care teams that build on each organization's community-based relationships to provide the core BH CP services. Other central administrative functions will be delegated to Members: Vinfen will provide IT, Marketing and Quality Management functions and Bay Cove will provide financial management and HR services to the EMCP central management team. Below are key milestones with timeframes for operationalizing the BH CP program:

- ACO relationship development – EMCP Members began planning sessions with several ACOs/MCOs nine months ago; these will continue until contracts are final in Spring 2018;
- Intake/referral system – EMCP will develop a system for accepting Enrollees from ACO / MCOs and assigning them to local care teams for engagement;
- Central management team start – key leadership positions including the Executive Director will begin in January 2018;
- Information Technology systems – EMCP will select a CCIT in September and configure the system for the following 6 to 9 months;
- Care team start up – Team Leaders will begin by May 2018; CCs and CCMs will begin by May; additional staff will be hired based on Enrollment volume.

In operationalizing the BH CP program, EMCP will develop infrastructures and capacities that will sustain the program over the Contract period and beyond. These structures include IT systems, a financial management system, a Quality Management program, a workforce trained in integrated care, a marketing platform for engaging Enrollees, an organizational governance

structure that facilitates the collaboration of three separate Member organizations under one umbrella, and integrated care relationships with ACO and MCOs.

7.3 B Supporting Populations and Community Engagement

1. As community based organizations providing care coordination services for decades to people with behavioral health challenges in Eastern MA in all the Service Areas (SAs) included in this proposal, we have extensive experience seeking out, using the resources of, and maintaining strong and enduring relationships, collaborations and partnerships with a wide and deep variety of municipal, state and federal social service agencies and community based organizations. In addition to the examples in the chart below, our relationships extend to local civic associations, faith based and community development organizations, municipal leaders, local housing authorities, elected officials, and academic institutions. Examples of our connections include:

Region/SAs *=Partnerships	Social Service / Municipal / Community Organizations	Behavioral Health Service Providers	Housing & Homeless Services
Northern: Haverhill	Community Action of Haverhill, Pettingill House, Buttonwoods, Sarah's Place	Holy Family Hospital, Whittier Pavilion, Anna Jaques Hospital	Community Teamwork, Ruth's House, Emmaus Inc.
Northern: Lawrence	Valley Works Career Center, Lawrence Drug Court, People Care Clinic, Lawrence Sr Ctr	Center for Psychiatric Medicine, Greater Lawrence Family Health, Lawrence General Hospital	Lazarus House, Project Home
Northern: Lowell	Lowell Drug Court, Lowell Adult Day Treatment*, Bridgewell Diversion Program*	Lowell Treatment Center, Lowell Community Health Center, Harvard Vanguard	Jaycee Place, Janet's Place, Lowell Transitional Center
Northern: Lynn	Healthy Streets, Lynn Drug Court, Gtr Lynn Senior Services	South Bay Community Services – Clinic, Lynn Comm Health	Coalition for the Homeless
Northern: Malden	Mystic Valley Elder Services	South Bay Community Services, Melrose-Wakefield Hospital	
Northern: Salem	Project COPE Clinic*	South Bay Community Services – MH Clinic	LifeBridge, Sutton Home for Women
Greater Boston: Boston	Pathways 2 Hope & Recovery, Hearth*, South End Community Health Ctr*, Pine Street Inn*, North Suffolk Mental Health*, Kit Clark Senior Services*, Triangle Program*, City Psych*	Commonwealth Care Alliance*, Boston Medical Center*, Tufts Medical Center, Fenway Community Center, Marie's Place*, Massachusetts Mental Health Center*, Carney Hospital	Homestart, On the Rise, HousingWorks, Rosie's Place, Health Care for the Homeless,
Greater Boston: Revere	Community Substance Abuse Ctr, Project COPE Clinic*	MGH Revere, CHA - Revere	
Greater Boston: Somerville	Cambridge Multicultural Center, Somerville Police Jail Diversion*, Somerville-Cambridge Elder Services*, Recovery Court, BEST, Transition House, CCAN	Cambridge Health Alliance*, Riverside Community Health Ctr, St. Elizabeth's Hospital, Zinburg Clinic, Somerville Hospital, North Charles Institute for Addictions	Homestart, On The Rise, Metropolitan Boston Housing, Heading Home, Y2Y
Greater Boston: Quincy	Wellspring Adult Learning /GED Program*, Discovery Day Treatment, Marge Crispin Ctr	Arbour Counseling, Westwood Lodge, Quincy Center, Walden Behavioral Health*	Program, Mainspring Shelters, Father Bill's Place
Southern: Attleboro		Attleboro Mental Health Clinic	
Southern: Barnstable	Barnstable County Dept of Human Services, Behavioral	Boston Medical Ctr* (ESP, CSU), Duffy Health Ctr, Gosnold,	St. Joseph's Shelter, Housing Assist Corp,

	Health Provider Coalition of CCI	Arbour Counseling, Cape Behavioral Health	CC Needy Fund
Southern: Brockton	Youth Build, House of Possibilities	Brockton Hospital, BAMSI, Good Samaritan Medical Center Brockton Signature Health, Brockton Crisis	Mainspring House
Southern: Fall River	SSTAR	Boston Medical Center* (ESP, CSU), Charlton Memorial Hosp.	
Southern: Falmouth	Falmouth Service Cntr, NAMI Cape Cod, Behavioral Health Provider Coalition of CC & I	Boston Medical Center* (ESP, CSU), Gosnold, Arbour Counseling, CapeCod Healthcare	Carriage House Shelter, Housing Assistance Corp
Southern: Nantucket		Fairwinds	
Southern: New Bedford		Southcoast BH, Greater New Bedford Community Health Ctr, St. Luke's Hospital	
Southern: Orleans	Barnstable County Department of Human Services, Behavioral Health Coalition of Cape Cod / the Islands, NAMI Cape Cod	Outer Cape Health Services	Lower Cape Outreach Council, Provincetown Housing Authority
Southern: Plymouth	Plymouth Mental Health Court, Plymouth Council on Aging, Plymouth CCS, Anchor House, South Shore Community Action Counseling, Cameron's House	Pembroke Hospital, North River Counseling, DuxburyCounseling, High Point, Harbor Community Health, Beth Israel Deaconess Hospital, South Shore Hospital	So Shore Women's Center, Pilgrim's Hope, Plymouth Area Coalition, Housing Solutions
Southern: Taunton	CCBC-Pathways DBT, Harmony Adult Day Heath	Taunton State Hospital	
Southern: Wareham	Council on Aging	Bay view Associates Counseling, Habit Opco, Hawthorn Medical	Father Bill's, Damien's Place

All Service Areas – Relationships with State & Local Chapters			
Social Service / Community Organizations	**Advocacy Groups**	**BH Service Providers**	**Housing/Homeless Services**
Social Security (SSI/SSDI); MA Depts of Elder Affairs, Mental Health, Children and Families, Public Health, Transitional Assistance; MassHealth; MA Rehab. Commission; MBTA; DHCD; Catholic Charities; Red Cross; YMCA; Food Pantries	MA National Alliance on Mental Illness, Association for Behavioral Health, Providers Council, MA Organization for Addiction Recovery, the Transformation Center & Independent Living Centers	Multiple PCPs & Primary Care Practices	HUD subsidy programs, JRI Housing Options, Local Housing Authorities; MA Coalition for the Homeless

2. We will use our expertise in seeking out and developing partnerships to further enhance our resources, provide supports that reflect the needs of those we serve in All Service Areas, and strengthen our collaborations in All Service Areas by:

- Tasking Program Directors with developing and strengthening future collaborations
- Targeting the needs of high users of services to coordinate care plans with Enrollees and their network of helpers to optimally address their needs
- Marketing the benefits of Care Coordination based on our previous experiences
- Using written materials and face to face meetings to establish networks with community, social, and health care providers our Enrollees identify as valuable in their lives

3. After decades of developing and sustaining community collaborations, EMCP will bring comprehensive regional resource toolkits to our staff to which they will be oriented as part of

their initial training. EMCP Members will maintain these specific and up to date resources with contact information online to be accessible to all staff. As we identify new community resources, these resources will be routinely shared in supervision, staff meetings, email, and in-service trainings.

7.3 C Community Partner Supports and Activities

EMCP's work will be predicated on effective practices in eight domains: 1) Outreach and active engagement, 2) Comprehensive assessment and person-centered treatment planning, 3) Provision of care coordination and care management, including enhancement of Enrollees' access to health care, 4) Support for people through critical transitions in care, 5) Provision of safe medication reconciliation, 6) Provision of health and wellness coaching, 7) Connection to Community and Social Services, and 8) Community Collaboration and Coordination. EMCP Members bring extensive and demonstrated expertise in all these activities.

To provide the CP supports and activities described in this Section 7.3 C, each Member will develop one or more locally-based Care Teams that include Care Coordinators (CC), Clinical Care Managers (CCM) and a Project Coordinator. Each care team will be supervised by a Team Leader who is a Licensed Professional of the Healing Arts (LPHA). Care Coordinators are Health Outreach Workers (HOW) or Recovery Support Navigators (RSN) and may also be a Certified Community Health Worker, Certified Peer Specialist and/or filled by someone with lived experience. EMCP estimates hiring two HOWs for every one Recovery Support Navigator based on the assumption that about one-third of Enrollee will require people with SUD expertise. The Care Teams will also include Clinical Care Managers (CCM) who are licensed as an LMHC, LICSW or LMFT or RN. EMCP estimates hiring an equal number of LMHC/LICSW/LMFT staff as RNs to serve as Clinical Care Managers. Section 7.3 E further describes the care team staffing.

1. Outreach and Engagement

EMCP will begin outreach efforts to engage Assigned Enrollees with an appreciation that care management through the BH Community Partner (CP) program can be of great benefit to them and their overall health. In many ways, the current health care system falls short in attending fully to the needs of people who are poor and live with the daunting challenges of Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD). People are challenged by significant cognitive impairments, symptoms related to their psychiatric conditions or SUD, and side effects of medicines. People with SMI and/or SUD have a higher prevalence of exposure to interpersonal trauma which is recognized as interfering with engagement of helpers. Housing instability, homelessness, hunger and food insecurity are commonplace. Many people also find their natural support networks lacking. Overall, these collective and limiting factors lead to health disparities and create formidable barriers that impede people's chances of engaging with providers and embracing health promotion strategies and tools.

The ultimate goals of delivering improved health outcomes and containing costs for MassHealth's prioritized population are dependent on successful outreach and engagement activities. Without successful engagement, an Enrollee will not have access to or benefit from

key CP functions such as care coordination, health and wellness coaching, connection to social services, and care transitions supports. Thereby, EMCP will prioritize engagement in the first year of the program through the development of an Engagement Strategies Library and in targeting Engagement as the first year's Quality Management program initiative. As discussed in Section 7.5 I, EMCP will closely measure progress on particular steps in the engagement process to determine how the work can be improved.

EMCP will receive referrals of Assigned Enrollees from ACOs, MCOs and EOHHS directly. Upon receipt, EMCP will notify the referring organization within one business day to confirm receipt and will open an Enrollee record in EMCP's CCIT. Anticipating a high volume of referrals in the first 18 months of the program, EMCP will develop dedicated Assessment Teams responsible for the initial outreach, engagement, consent, assessment and care planning work with Assigned Enrollees. Two of the three Consortium Entities, those two with the higher capacity, will each have an Assessment Manager to oversee these start up teams. Upon assignment to EMCP, the Assigned Enrollee will be assigned to a member of the Assessment Team. Assessment Teams will remain in place through the high-volume referral periods. As referral volume decreases and EMCP's designed Capacity is reached, designated Assessment Teams may no longer be necessary, and Assessment staff will be included in the Care Teams.

An extraordinary strength of EMCP is our collective proficiency in engaging and partnering with people with excessive vulnerabilities and supporting them in building healthier lives and better futures. This expertise, as informed by evidenced based and promising practices as promoted by SAMHSA-HRSA's Center for Integrated Health Solutions (www.integration.samhsa.gov) and the National Health Care for the Homeless Council's Outreach & Enrollment Quick Guide: Promising Strategies for Engaging the Homeless Population (www.nhchc.org), will steer the efforts of our Assessment Teams. EMCP's initial and ongoing outreach and engagement campaign as launched by CP Assessment Teams will employ a variety of honed techniques and practices, including:

- **Meet people where they are.** EMCP teams will accommodate an individual's preferences in location, frequency, and duration of meetings in an effort to build trust and be supportive.
- **Describe and demonstrate usefulness of BH CP services to encourage Enrollee participation**. In that some Enrollees will be reluctant to engage, EMCP will provide concrete information on the practical ways the BH CP program will provide support.
- **Ensure communications meet the person's cognitive and language skill level**. EMCP teams understand how nuanced communication must be and will tailor speech (pace, pitch, cadence) and language to meet that of an Enrollee's.
- **Address concerns that people bring up in a hopeful and non-judgmental manner.** Some people experience confusing or troubling thoughts, symptoms, and triggers that emerge when meeting new people or considering changes. EMCP teams will respond respectfully and kindly to such experiences, paving the way for the individual to focus on accessing and using health care services.
- **Bring experience that addresses the cultural and linguistic needs of the population prioritized by EOHHS**. EMCP takes great pride in our commitment and ability to employ teams that reflect the cultural and linguistic needs of those we serve. EMCP meets both the cultural and linguistic needs of the populations who will be served. EMCP will tailor outreach materials to meet the predominant languages and prioritizes hiring team members who reflect the richness and diversity of those communities.

- **Understand that predicting who will engage in services is not possible.** EMCP suspends assumptions that can be commonplace for many professionals. EMCP will provide all Assigned Enrollees with the opportunity to engage in the BH CP program at their pace.
- **Customize engagement strategies to address interests and needs.** EMCP will tailor engagement to different populations. Care Coordinators receive ongoing training and support that identifies engagement best practices based on distinct needs in relation to gender differences, LGBTQ status, homeless status, and those overwhelmed with addiction. EMCP will develop an *Engagement Strategies Library* based on Members' experience prior to the start of the program and will update the library throughout the Contract obtaining input from Care Coordinators.
- **Support enrollees to identify and cope with those who interfere with engagement**. Sometimes family members, friends, neighbors, landlords and others can be intrusive or disruptive to people facing choices. EMCP teams will manage people who pose challenges to an Enrollee's capacity to embrace services, and teach people how to access health care despite these challenges.

a. Planned strategies for outreaching to and engaging with Assigned Enrollees, including individuals who are homeless and hard to reach

Health care providers and insurers describe "patient finding" as a practical obstacle they face in engaging people in services. EMCP brings pragmatic skills and flexibility to community engagement efforts, particularly for people who are homeless. We meet people where they live, whether in a temporary housing situation or unsheltered situation. In this endeavor, we will:

- Find people through local homeless outreach teams, shelters, homeless services, and drop in centers.
- Collaborate with other providers in Assigned Enrollees' care networks.
- Engage in street outreach, approaching people on the street in a safe and respectful way.
- Outreach to people in unique environments, such as a homeless encampment or non-traditional housing. If a particular living situation is unsafe, Care Team Members will arrange to meet an Assigned Enrollee at a local coffee shop, park, or public building.

b. Planned strategies for outreaching to and engaging with Assigned Enrollees with Substance Use Disorders (SUD)

EMCP teams have extensive experience reaching people who may be actively using substances. As such, in addition to the above mentioned engagement practices, our teams are well versed in employing strategies specific to those with SUD. We will approach outreach and engagement activities informed by: our current and ever evolving knowledge of SUD; our understanding of the impact these disorders have on the overall health, wellness, and quality of life of those we serve; and the widely implemented engagement strategies as employed within the field of SUD services.

- **Employ and deploy Recovery Support Navigators**: When EMCP Enrollment is at its designed Capacity, EMCP local Care Teams will include 18 Recovery Support Navigators (RSN) to serve people with SUD. If EMCP learns that there is a higher prevalence of SUD among Enrollees than is currently projected, EMCP will employ more RSNs and fewer Health Outreach Workers.
- **Address stigma**: EMCP teams are well trained in recognizing such biases, in oneself, in others, and in our institutions, and in recognizing the negative impact such biases have on

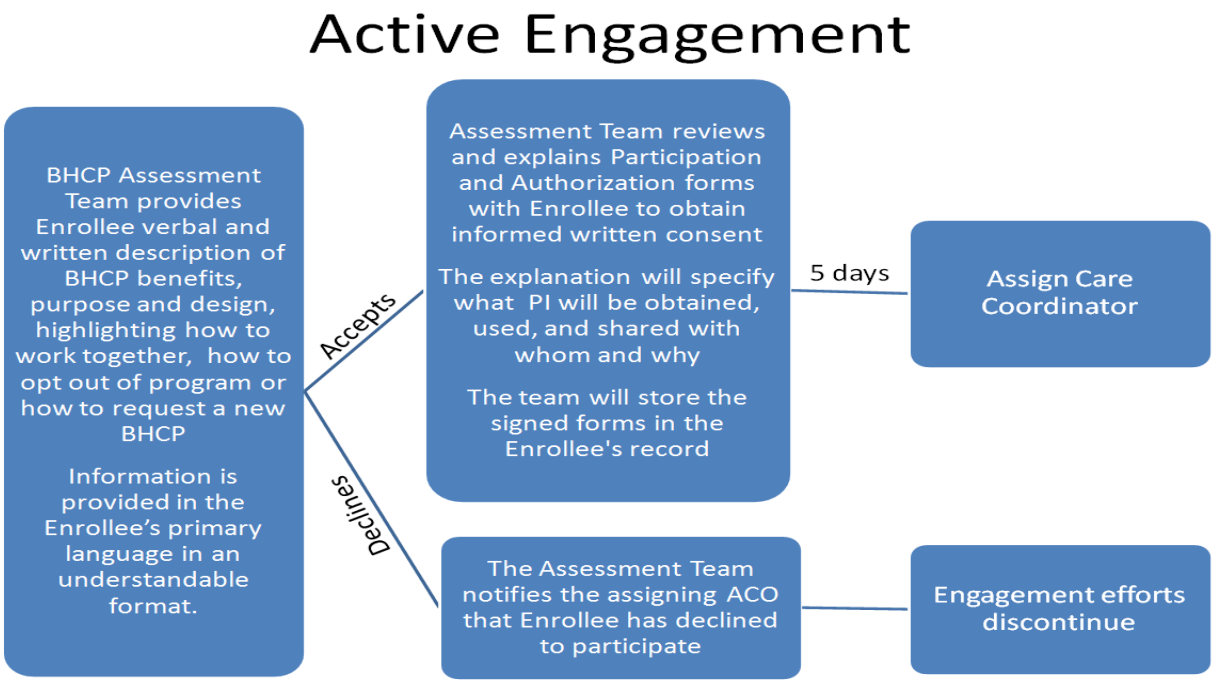
persons served. This code of ethics is crucial in our work with people living with SUD. It reflects EMCP's mission, promotes authentic connections, drives engagement and leads to more effective treatment relationships.

- **Inclusion of people in recovery on Care Teams:** EMCP promotes the inclusion of people in recovery on our teams. In addition to other skills team members in recovery bring, personal perspectives and experiences promote a unique level of trust and maximize the opportunity for both engagement and recovery.
- **Flexibility**: EMCP teams are practical in altering appointment schedules to engage people who may keep atypical hours, or who may be clean and sober for short periods of time on a given day.

c. Planned process to obtain and document Assigned Enrollee's agreement to participate in

CP Supports initiated through participation form and assignment to an Assessment Team

Anticipating a high volume of referrals, EMCP will develop Assessment Teams responsible for the initial outreach, engagement, consent and assessment work with Assigned Enrollees (Enrollee). Upon assignment to EMCP and no later than 30 days, Assessment Teams will outreach to Enrollees though phone, electronic means, home visits, and/or community based visits to describe the benefits of EMCP involvement. Teams will prioritize meeting Enrollees in person in order to most effectively explain the BH CP program and enhanced opportunities, and to thoroughly address questions and concerns an Enrollee may have. Teams will make multiple attempts to conduct at least one in person visit for each Enrollee within 90 days of assignment. At these initial meetings with Enrollees, Assessment Specialists will assess an Enrollee's expressed needs for pragmatic help, discuss potentially useful solutions, describe EMCP's benefits and follow the engagement protocol as outlined in the Active Engagement Chart below.



2. Comprehensive Assessment and Person-Centered Treatment Planning

a. **Process for conducting Comprehensive Assessments**
The Comprehensive Assessment (CA) and Person-Centered Treatment Plan (PCTP) serve as an essential foundation for the work EMCP will do in partnership with each Enrollee and their designated team. As such, we will implement protocols that will promote the level of an Enrollee's engagement necessary to capture a comprehensive summary of what they might want and need from the program. Similarly, we will seek to connect with the Enrollee in a manner that best fosters their active engagement in both the development and implementation of their PCTP.

Anticipating a high volume of referrals in the first 18 months of the program, EMCP will develop dedicated Assessment Teams responsible for the initial outreach, engagement, consent, assessment and care planning work with Assigned Enrollees. The Assessment Team's Clinical Care Manager will complete the first annual Comprehensive Assessment (CA) and PCTP with each Assigned Enrollee within 90 days of assignment. The Comprehensive Assessment will be completed with Engaged Enrollees annually thereafter. A Clinical Care Manager RN will review the Enrollee's medical history, medical needs and medication sections of the Comprehensive Assessment.

EMCP acknowledges that the most meaningful assessments and effective PCTPs are driven by the full participation of the Enrollee in the process. To this end, our teams will embrace the opportunity during assessment and planning meetings with the Enrollees to assure them of the full team's support, to lay the groundwork for engagement in health improvements and to highlight the impact that change can have on their health and quality of life. We will get to know each person, learning first-hand their life experiences and perceptions of the world, what they recognize as barriers to living a more healthy life, and what they identify as strengths and supports. We will make repeated efforts tailored to each individual to promote input into the assessment and planning process as much as possible or desired by the Enrollee.

As during the Active Engagement phase, EMCP Assessment Teams will capitalize on existing staff relationships with Enrollee's involved in organizational BH services to promote participation in the assessment and planning process with "warm handoffs." Additionally, the team will rely on other sources for information for the Comprehensive Assessment as permitted by the Enrollee, or Legal Authorized Representative (LAR) when applicable, with informed consent.

Senior program staff of EMCP Members, informed by their collective experience in Behavioral Health Homes, CBFS, and SUD programs, have drafted a Comprehensive Assessment Tool and a Person Centered Treatment Plan (PCTP). Please reference **Attachment 3**, which represents our proposed Comprehensive Assessment (CA) tool, at the end of this Section. Of note, EMCP Members are currently piloting the CA tool to assess how long it takes to complete and whether there are any areas that can be improved.

b. Process for conducting Person-Centered Treatment Plans (PCTP)
It is imperative for an Enrollee to participate in the care planning process. EMCP will promote a flexible environment that respects an Enrollee's process while making every effort to engage them.

Process for developing with Enrollee active participation: EMCP will use the results of the CA, and any other assessments conducted for the Enrollee, to inform the development of the PCTP. To promote active involvement by the Enrollee in this process, each Enrollee will be offered the opportunity to designate from his or her circle of family, friends, caregivers, and health care providers a Care Team of their choice. The Enrollee's Care Coordinator will then invite members of the designated team to participate in the initial care planning. The Enrollee will be encouraged to consider and develop specific goals that align with his/her interests and needs. As appropriate, CCs will partner with other known providers in an effort to locate and engage a hard to reach Enrollee and/or will make repeated efforts to engage him or her in this crucial process. And we will meet with an Enrollee as many times as indicated to facilitate active participation and approval of the PCTP. PCTPs will be prepared in the format understandable to the Enrollee and presented with a translator when necessary. As needed, the CC/CCM will seek input from the Member's Medical Director in assessing risk for the Enrollee and in developing a crisis plan.

Process for documenting: Following the approval of the PCTP by the Enrollee or LAR, the PCTP will be sent to the Enrollee's PCP or designee for approval. Upon PCP or designee approval, the Care Coordinator will document in the Enrollee's EHR. EMCP will use a Care Coordination Information Technology (CCIT) to document CP supports. This process will be completed within 90 days of the Enrollee's assignment to EMCP.

Process for updating: PCTPs will be reviewed and updated accordingly every six months, or as needed if major changes in functional or health status occur. The now Engaged Enrollee (Enrollee) may include any care team member in this review. Following Enrollee approval of the updated PCTP, it will be forwarded to the PCP or designee for approval.

Process for ensuring all approvals: EMCP will establish relationships with ACOs in EMCP's service area. As described in Section 7.3 J, EMCP will work with ACOs to develop communication and coordination protocols with primary care practices that are part of the ACOs. We will use these protocols for PCTP input and approval and ensure timely authorization of treatments for urgent needs. EMCP Care Teams will follow the protocol below for Person Centered Assessment and Treatment Planning.

3. Care Coordination and Care Management

There is emerging literature recognizing care coordination and care management practices that render improved health care access, patient experience, and outcomes. These include previously referenced practices such as ensuring that: roles, responsibilities, and goals across the care team are clear; the Enrollee is central to the PCTP development, approval, implementation and ongoing refining of goals relevant to their health conditions and wellness; the PCTP honors the cultural and linguistic values and needs of the Enrollee; and that important information is shared in real time across health practitioners and other key members of the care team. EMCP Members embrace these principles and will actualize them in the BH CP program.

Formation and Operation of the Care Team

During the outreach and engagement phase, an Assessment Team Member will interview the Enrollee and review the ACO referral information in order to determine all stakeholders involved in his/her care and those that could be included in the Care Team. The Enrollee will be encouraged to include others they rely on for support and assistance in their Care Team. Team members will at a minimum include the PCP or designee, the Clinical Care Manager (CCM) and Care Coordinator (CC), behavioral health practitioners and the Enrollee. Upon the Enrollee's wish, their team may also include advocates, natural support network members, specialists, community service providers and other members of relevant state agencies.

The CC will contact identified Care Team members to notify them of the Enrollee's assignment and participation in BH CP services, and the Enrollee's request for their participation on the Care Team. Individual roles and responsibilities appropriate to licensure and relationship to the Enrollee will be outlined. The CC will assume full responsibility for making and documenting efforts to address the Enrollee's health needs and treatment goals with the Care Team, and for maintaining and distributing team members' contact information.

The CC will focus coordination efforts on ensuring that an Enrollee accesses primary, specialty and behavioral health care and that their identified goals on their PCTPs are addressed. The CC will support the Enrollee to schedule and keep their health-related appointments and access transportation as needed.

The CC will remain the responsible person for coordinating with other members of the Enrollee's Care Team and ensuring that team meetings occur when necessary to address significant changes to health status or areas of need during time of care transitions. Options for care coordination modalities will include: multi-party conference calls, emails, shared documents through secure portals and in person meetings or as a larger group to emphasize efficiency for all parties involved.

Our efforts will operate within HIPAA requirements when coordinating services outside of the Care Team; for example, with the judicial system, Social Security Administration or other areas where Enrollees often benefit from assistance and coordination.

Coordination of LTSS needs

For Enrollees who have LTSS needs, EMCP Care Teams will provide LTSS coordination. Care Coordinators (CC) will coordinate routinely with involved service providers (often LTSS or CBFS providers) to ensure contracted community based services remain in place to address the Enrollee's needs and goals as outlined in their PCTP. Modalities for communication include options noted previously.

When Enrollees develop new need areas which require LTSS services, the CC will explain how a particular type of service can help to meet these identified needs and will provide the Enrollee with a choice of at least two providers, whenever possible, for that service to support personal choice. This service will be documented in the CCIT.

As Enrollees seek to access LTSS services, the CC will provide links, names and contact information for those Enrollees who are able to establish contacts independently. For Enrollees

requiring more assistance, an enhanced referral process will be expedited, including more detailed instructions regarding what a service entity provides, how to initially access the service, how to use it and how best to sustain ongoing communicate with the service. This information will be provided to the Enrollee in their primary language and in their preferred modality to ensure for their understanding. In the absence of the necessary skill base, a team member will accompany the Enrollee in person to access the services or care they require and to teach the Enrollee how to manage making service connections over time. The CC will add newly accessed service providers to the Care Team, establishing contact at time of referral and maintaining communications as previously detailed.

Coordination of Social Determinants of Health needs

EMCP Care Teams recognize that Social Determinants of Health (SDH) needs are considerable within the MassHealth prioritized population. Given that so many of those within this population face ongoing challenges as associated with poverty, unemployment, food insecurity, unstable housing, and poor access to health care, our care teams will assess SHD needs in an ongoing way and prioritize these needs with an Enrollee and their Care Team. Attention will be paid to a range of SDH need such as:

- Economic Stability: Our teams are well versed in supporting people in securing all benefits for which they are entitled, including utility assistance and cell phone assistance, and in achieving food security and housing stability.
- Education/Employment: As needed, our teams support people in seeking educational opportunities, vocational training, job placement services, employment opportunities as well as language and literacy classes.
- Health Literacy/Health Care Access: For many, a crucial support in this area relates to ensuring that the cultural and linguistic needs of people served are met as they access their health care providers. Our teams prioritize the health literacy of those we serve, and promote engagement in preventative health measures such as physical activity and balanced nutrition.

Person-Centered Care Coordination

Care Coordination efforts will be tailored based on each Enrollee's individualized needs.

- For Enrollees who are proficient at accessing care, participating in decision making and following health care provider recommendations independently, CC's will routinely communicate with the Enrollee and provide guidance and information as needed to ensure successful health care use, including properly following prescribed medication regimens.
- For Enrollees less capable of doing so, CC's will provide a greater level of assistance and coordination. For example, this may include providing reminders for attendance at scheduled appointments; assistance in arranging for transportation; or teaching Enrollees how to prepare for appointments and the skills central to shared decision making.
- Enrollees who lack the primary skill base required to access and use care will receive comprehensive interventions which may include more routine in person coaching by a team member, appointment scheduling, and instruction regarding how to practically apply provider recommendations in the environment in which they are performed and/or to follow prescribed medication regimens.
- For those Enrollees who have a Legal Guardian involved, CC's will additionally work with the guardian and involved care team members to facilitate their access to care.

Medication Adherence

A key factor in improving an Enrollee's health, and health outcomes overall, is medication adherence. EMCP Care Teams will employ a number of strategies to support Enrollees in adherence to their individualized medication regimen, including:

- Developing relationships with local pharmacies to expand abilities to provide quick response to medication changes, unique packaging solutions and delivery.
- Identifying people or organizations that can support the Enrollee in taking medications including visiting nurse associations.
- Coordinating with the Enrollee's Medication Assistance Program (MAP) provider
- Utilizing medication reminders via calls or text messages as helpful to an Enrollee. Of note, per arrangements with ACOs/MCOs, EMCP hopes to designate DSRIP funds to evaluate technologies such as "MedMinders" to support individuals with medications rather than rely on more costly VNA visits for simple medication administration (see Section 7.3 D).

Also of note, as delineated in Section 7.3 D, EMCP will, in collaboration with select ACOs, use a modest amount of DRSIP funds to evaluate the cost effectiveness of remote patient monitoring tools, to engage individuals with complex problems who have the capacity to use systems to connect with caregivers and self-manage specific health problems. EMCP will implement a pilot program with 20 Enrollees in Budget Years two and three.

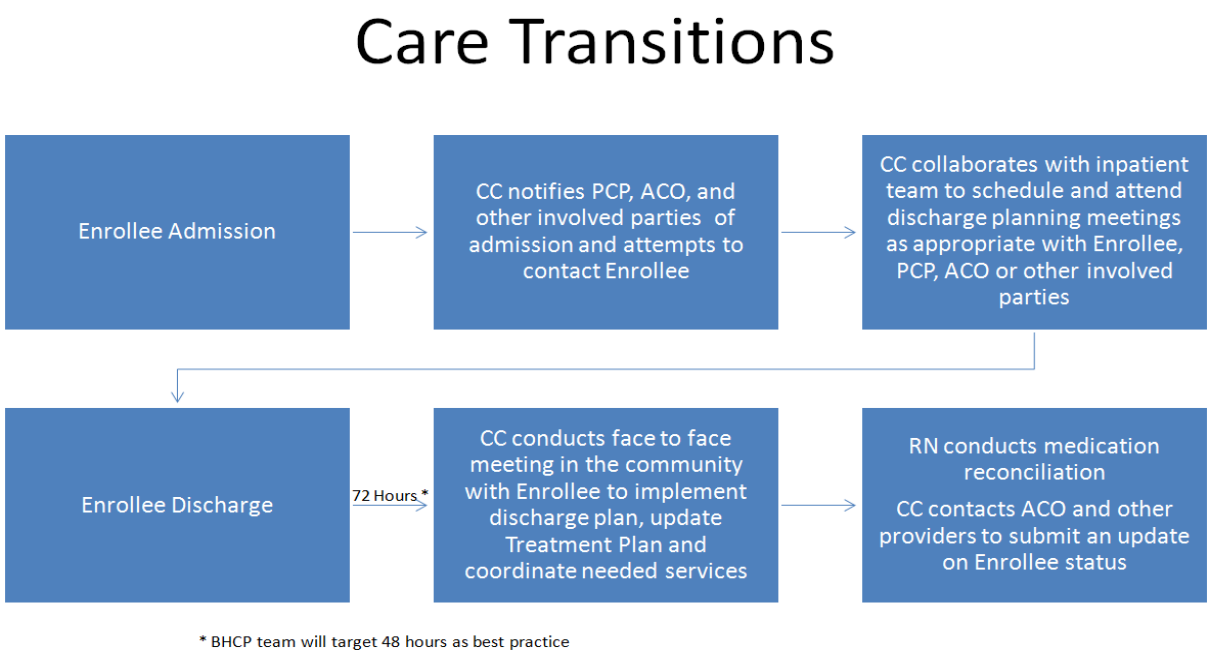
4. Care Transitions

It is critical to provide Enrollees well-coordinated and optimal care during times of admissions and discharges. Care Transitions represent a time of great vulnerability for people experiencing an exacerbated physical or behavioral health condition. Conversely, when people's conditions stabilize and improve, they again often faces challenges as they make adjustments upon returning home. Depending on the nature of an Enrollee's health concern, they may require medications, changes in health practices and diet, and likely require follow up care. Many factors affect the success of care transitions: time available for transition planning; when and where the transition occurs; the Enrollee's health status and personal resources and supports; the Enrollee's perception of the transition; and communications and cooperation across different systems and organizations. Common care transitions within this population include:

- Admissions to or discharge from higher levels of care in Behavioral Health settings such as inpatient psychiatric hospitalizations, detoxification programs, crisis stabilization units and respite programs
- Admissions to and discharges from inpatient medical hospitals for acute medical conditions
- Transitions of care between inpatient settings and skilled nursing facilities (SNF)
- Discharges from correctional facilities that require re-entry planning and supports
- Discharges precipitated by a person's behavioral concerns, as can occur in many voluntary treatment programs, should a person violate safety rules that compromise care for others (if the individual uses illegal substances or engages in problematic behaviors)
- Transitions in care that occur when a service requires immediate evacuation

Regardless of the nature of a care transition, the Care Coordinator will assist the Enrollee in navigating through all changes associated with the transition from one setting to another. EMCP Care teams will:

- Prior to inpatient discharge, coordinate with facility discharge planners, and other Members of the care team as appropriate to develop a discharge plan.
- Attend discharge planning meetings that include the Enrollee and facility staff.
- Conduct a face–to-face visit with the Enrollee within three business days of the inpatient discharge that includes medication reconciliation and an update of the PCTP.
- Assess whether the Enrollee's home environment is safe for return and will arrange for additional LTSS or social services that may be needed upon the Enrollee's arrival home.
- Review Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) to identify new LTSS and/or social service supports that need to be arranged. Following a Care Transition, the Enrollee may return home and need to pay bills, secure groceries, necessary medical supplies and medications, and attend to laundry.
- Provide important resources and assistance to the Enrollee to support use of existing or newly referred providers.
- Support new providers in connecting with the Enrollee and relevant members of Enrollee's natural support network, capitalizing on "warm hand-offs" as often as possible and role modeling to new providers regarding how best to engage the Enrollee.
- Offer transportation coordination and skills training to supplement organizational strategies required to ensure attendance at scheduled follow up appointments.
- Exchange relevant information with involved parties to coordinate care.
- Prioritize discussion with Enrollee to assess level of satisfaction following transition and current stability to prevent further upheaval.



5. Medication Reconciliation

Psychiatric and medical symptoms, substance use, chaotic lifestyles, and fragmented care with multiple prescribers all compound the challenge of providing proper medication regimens for people living with complex, co-occurring behavioral and medical health issues. Therefore, it is critical to complete medication reconciliations and to establish systems to help Enrollees access newly prescribed medications. Utilizing effective Medication Reconciliation procedures ensures for safety and can reduce the need for readmissions and emergency room utilization. A Clinical Care Manager (RN) will perform medication reconciliation for Enrollees who have been discharged from an inpatient setting including coordinating with the Enrollee's PCP to ensure that any new orders from the inpatient setting are appropriate, verifying that the prescriptions were filled accurately, ensuring that the Enrollee understands how to take the medications, and reviewing any discrepancies or issues with multiple prescriptions. The Care Coordinator will employ methods discussed in Section 7.3 C 3 to support Enrollees to adhere to medication recommendations. The three major steps will drive the medication reconciliation process:

- **Verify:** RN contacts prescribing providers to obtain Medication Orders
- **Review and Reconcile:** RN reviews medications in person with the Enrollee to ensure that they are filled accurately; if there are discrepancies, RN will coordinate with the pharmacy and/or prescribers to reconcile.
- **Educate Enrollee:** RN discusses medication regimen with Enrollee and checks verbally for understanding; RN provides instructions to support the Enrollee to follow; RN identifies supports for the Enrollee including technologies as discussed in Section 7.3.D and/or people who might support the Enrollee. If Enrollee is unable to follow the regimen, RN will notify prescribers and make recommendations for changes to improve adherence. RN will notify the Enrollee's MAP program if applicable.

6. Health and Wellness Coaching

a. Health and wellness education, coaching and health promotion programs to be utilized
Making changes in everyday practices that align with improving health and wellness is a challenge for the majority of individuals and families in the Commonwealth. EMCP is well versed in best practices that will inform our health and wellness coaching with Enrollees and will bring to Enrollees resources and supports that build on industry expertise: Motivational Interviewing, Cognitive Behavioral Therapy Breathing Retraining, WRAP (Wellness Recovery Action Plan), SAMHSA Integrated Treatment for Co-Occurring Disorders, utilization of DBT practices, Seeking Safety, employing emerging cultural adaptations to EBPs, Integrated Illness Management and Recovery materials, WHAM (Whole Health Action Management), WRAP for Addictions, and Trauma Informed Care.

Joan Kenerson King of the National Council of Community Behavioral Health attests that health change is potentiated when a person has: a support system comprised of people who believe in you and your capacity for change even before you did; knowledge and education to approach change; a person to help you make small – tiny – steps toward change; a way to monitor change and someone to hold you accountable; celebration of small achievements in the change process. ("Inciting Health Behavior Change through Consumer Engagement" SAMHSA- HRSA Center for Integrated Health Solutions, www.integration.SAMHSA.gov)

As noted previously, an important ingredient of EMCP Care Coordinators' orientation will be to partner with Enrollees in an affirmative, respectful, and hope carrying manner. Wellness coaching is predicated on being able to genuinely communicate a belief in a person's potential, regardless of their limitations. Care Coordinators will offer information, resources, and generous support to reinforce all efforts made in the service of healthy change. Additional Health and Wellness coaching activities will include:

- Utilizing SAMHSA's Eight Dimensions of Wellness as a starting point for treatment planning and wellness coaching activities. Principles may be referenced with Enrollee and other care team members in an ongoing way.
- Addressing lifelong patterns of unhealthy behaviors by identifying Enrollee barriers or misconceptions, providing education and skills training, addressing lack of resources and using motivational interviewing to promote behavioral change with a primary focus addressing high risk behaviors and health risk factors.
- Utilizing resources through promising practices such as SAMHSA's Program to Achieve Wellness (PAW).
- Supporting Enrollees to address high risk behaviors and health risk factors by encouraging participation in smoking cessation, nutrition programs, exercise, safe sexual health practices, sleep hygiene and weight loss.
- Focusing on small steps that Enrollees can take that can have a big impact on health. Care Coordinators will support Enrollees working on weight loss and share the value of the "Less is More" initiative. ("Inciting Health Behavior Change through Consumer Engagement" SAMHSA-HRSA Center for Integrated Health Solutions, www.integration.SAMHSA.gov). This initiative promotes the valuable benefits that a 5% weight loss can bring to overall health.
- Assisting Enrollees to access primary health care more effectively in order to reduce overreliance on emergency rooms. CCs will provide coaching that is individualized to address each person's specific barriers to accessing care and communicating with providers effectively.
- Improving implementation of healthcare provider recommendations into daily practice by addressing barriers and clarifying expectations with Enrollees. CC's will teach Enrollees how to employ recommended health practices in their homes, when they are with family or friends, and at work or other environments.
- Expanding capacity for Enrollees' self-management of chronic health conditions and routine use of preventive health care through coaching, attendance at workshops in local community settings, and increased access to information and supports on line on issues such as stress reduction and relapse prevention. CCs will support Enrollees to address and manage symptoms of chronic illnesses to improve their quality of life.
- Encouraging Enrollee's consideration of and participation in community based recovery supports such as 12 Step, dual recovery groups, use of the activities that are most helpful to them, faith communities, meditation groups and other personal practices that support spiritual wellness.
- Encouraging Enrollees to connect in area of interests such as playing sports, joining local reading groups, walking/running groups, partaking in local activities (RLC, drop in educational/learning opportunities) that both reduce isolation and enhance joy and a sense of purpose.

b. Methods for ensuring that the Enrollee's goals for health and wellness programs are recorded and tracked in the Enrollee's PCTP/Plan

In an effort to advance the health and wellness of Enrollees, it will be important not only for EMCP to offer all the supports delineated above, but to promote the inclusion of an Enrollee's specific health and wellness goal within their respective PCTP. As such, progress made towards a PCTP goal will be recorded within the Enrollee's Health and Wellness component of their EHR in the program's Care Coordination Information Technology system (CCIT) and reviewed regularly with an Enrollee. In partnership, the CC and Enrollee will track steps being made towards a goal, as well as goal achievement, and any revisions indicated to an Enrollee's PCTP will be made accordingly. These progressions will be tracked within an Enrollee's EHR.

7. Connection to Community and Social Services

The Institute of Medicine emphasizes the importance of integrating community and social services as they are requisite to Care Management planning and compliment the effectiveness of Care Coordinators' roles in addressing both health outcomes and cost concerns. Likewise, the National Quality Forum identifies preferred practices that further reify the merits of including community based non-clinical and social supports in addressing healthcare quality. They promulgated the National Voluntary Consensus Standards for Care Coordination which argue for inclusion of housing, social services, environmental, public health, and transportation to be identified as resources essential to an individual's health. (NQF, *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report,* Washington DC: NQF; 2010).

As discussed in Section 7.3 B, EMCP Members have extensive partnerships with a rich array of community organizations and resources that we will leverage to address health access, equity, and outcomes on behalf of EMCP Enrollees.

a. Plan to evaluate the Enrollees need for social services

There are several points in our relationship with Enrollees where we will identify whether the Enrollee has service needs that cannot be met through a MassHealth covered service or can be more effectively met through a Flexible Service. Those opportunities include:

- the initial in-person CA and PCTP development process
- the re-assessment / PCTP update
- care transitions and in particular discharge planning and post-discharge home visits
- through coordination with Enrollee's existing service providers including staff in other programs operated by EMCP Members (e.g. CBFS or residential staff), the Enrollee's PCP, the Enrollee's BH provider
- through communication with the family members of the Enrollee's care team

At these times, we will partner with the Enrollee to determine current needs for community based, social or Flexible Services and as indicated, will address these needs and services within

Enrollee's initial PCTP or updated PCTP. In turn, our CC's will partner with enrollees to tailor supports that best promote an Enrollee's capacity to function as independently as possible. When an Enrollee needs to access necessary community based services, we will provide links, names and contact information to Enrollees who are able to establish contacts independently. For Enrollees who need more help, an enhanced referral process will be provided, including more detailed instructions about what a service entity provides, how to access it, how to use it and how best to communicate. This information will be provided to the Enrollee in their primary language and by preferred modality to ensure understanding. If the Enrollee is assessed as unable to navigate the needed service, a team member will accompany the Enrollee in person to access the services or care and to teach the Enrollee skills necessary to access services over time.

b. Plan to ensure Care Coordinators are familiar with a wide breadth of social services and supports, and providers of these supports

EMCP Care teams will be trained to identify services that can be provided through the ACO's Flexible Services fund that are substitutes for more expensive services. Through our contracts with Commonwealth Care Alliance (CCA) for One Care Health Home services, we have extensive experience conducting assessments and developing care plans that identify and arrange for services that are outside of MassHealth's Covered Services. And as previously described, our teams will be oriented to a full array of community-based social services as part of their orientation and training. Resources available are specific to: housing stability (securing affordable, safe housing if homeless, housing retention, having heat and electricity), transitional support for Enrollees moving into the community from institutional settings; personal safety (should the Enrollee require supports to address domestic violence, for example), wellness (in varied wellness domains), nutrition and food security, securing/retaining benefits and entitlements, securing needed caregiver or family supports, getting help with money management or legal assistance, and utilizing as needed harm reduction supports.

EMCP Care teams will maintain updated lists of services on our web portal, with specific descriptions of these services, contact points, phone numbers, and emails and a list or link to eligibility requirements. As resources change, they will be updated on our web-based portal and staff will be notified of changes though team meetings, supervisions, and/or email communications. We will coordinate with community service providers to deliver services with the focused intention of teaching the Enrollee to manage independently, thereby decreasing the Enrollee's reliance on paid supports over time. These health and safety oriented services will be maintained to extend Enrollees' community tenure, to address social determinants of health, and avoid or reduce over reliance on acute and emergency services. We will inform the ACO, PCP and Care Team of community based, social or Flexible Services obtained to ensure comprehensive Care Coordination and will follow up with Enrollees to ensure services are properly provided.

c. Planned strategies for collaborating with ACOs to recommend Flexible Services on behalf of Enrollees, and following up on the outcomes of such supports

In initial conversations with ACOs/MCOs Bidders, EMCP has identified Flexible Services access as an area for which we will need to develop protocols. We will continue discussions to determine how EMCP can partner with ACOs to arrange for Flexible Services when it is the most effective way to serve an Enrollee and when it substitutes for a more costly medical

service. EMCP anticipates a process where a Clinical Care Manager or Care Coordinator identifies a Flexible Service need, submits a request to the ACO/MCO, ensures that the Service is purchased and implemented, and tracks the impact / effectiveness of the service. EMCP Member's Bay Cove and Vinfen have arranged for and authorized Flexible Services for One Care Enrollees through their One Care Health Home contract with CCA. The below are examples of Flexible Services that may support Enrollees:

- Companion services to help Enrollees who need support to attend appointments, shop, or learn how to use public transportation
- Non-medical transportation to/from the grocery store or a Clubhouse (DMH funded).
- Heavy chore services for people who are at risk of eviction
- Home supports that improve health outcomes such as room darkening curtains, special lamps to address depression, bedding/pillows for people with COPD, lumbar chairs
- Medical supplies such as a heating pad, knee brace, or adult diapers
- Technologies such as those described in Section 7.3 D for remote patient monitoring

8. Community Collaboration and Coordination

EMCP will collaborate and coordinate with community-based and state agencies on behalf of Enrollees. Please reference previous Section 7.3 B for a summary of many of these types of community based organizations and state agencies and PCP practices with whom we have developed effective partnerships that we will leverage as a BH CP.

Additionally, EMCP Care Teams will:

- Coordinate with any other case management services an Enrollee receives to eliminate duplication of efforts, a critical element to good care coordination efforts. We will provide verbal and written explanations to other existing case management providers regarding the role of the Care Coordinator, the benefits and design of the BH CP model to assess duplicative efforts, and we will make recommendations for changes to services to allow the BH CP model to supplement rather than duplicate existing services.
- Include CBFS, PACT, MAT providers in the Enrollee's Care Team to ensure effective communication aligned treatment goals and a unified approach to care. We will assume all responsibility for establishing and maintaining these relationships and collaborations.
- Partner with the Enrollee and the CBFS provider to ensure the Enrollee has access to routine and specialty medical care and the tools or services required to follow recommended actions, to develop a Crisis Plan to improve community tenure and decrease involvement with the criminal justice system and acute care services, and to establish shared treatment goals to improve health and wellness.

7.3 D Innovative Technologies for Service Delivery

Since 2011, EMCP Members Vinfen and Bay Cove have partnered in several projects evaluating the potential contributions of innovative technologies to improve the health of clients with SMI and/or SUD and to reduce health care costs.

- In a Behavioral Health Home program, funded by a three-year Centers for Medicare and Medicaid Services Innovation award, Vinfen and Bay Cove embedded nursing and outreach

staff into Community Based Flexible Supports (CBFS) teams. The Behavioral Health Home clients were also provided with a Health Buddy, remote patient monitoring technology developed by Bosch. The results of the combined intervention significantly reduced Emergency Department (ED) visits and psychiatric hospital days. The program was evaluated by Stephen Bartels, M.D., of The Dartmouth Institute.

- Bay Cove and Vinfen are working with The Dartmouth Institute in a 5-year, National Institute of Mental Health (NIMH) funded study to understand the benefits of deploying the Phillips Telestation with CBFS clients. At the two and a half year point and about 80% of the intervention group enrollment, Emergency Department visits and hospital days for the Telestation group are at rates of about one third of the control group.
- Vinfen has also evaluated a Wellframe smart phone application for remote monitoring and self-management coaching which showed sustained engagement (70% over one year) with young adults and improved self efficacy. A follow up three year evaluation funded by the Blue Cross Blue Shield Foundation of Massachusetts is showing positive results using an expanded self-management library.
- Vinfen and Bay Cove have deployed MedMinders with the goal of helping clients take their medications on time and reducing unnecessary visits by Visiting Nurse Associations (VNA). Pharmacies pre-package medications in trays, and an RN inserts and locks the trays in the MedMinder device, which alerts the user to access medications at the appropriate time. Data is fed to an internet based dashboard for staff. This program has been part of Vinfen's contract for One Care Health Home services and has contributed to a 15% reduction in VNA spending.

In the BH CP program, EMCP will use several types of innovative technologies. As discussed in **Section 7.2 E**, all care team staff will be assigned a laptop computer, will use a smart phone and will document in EMCP's Care Coordination Information Technology (CCIT). In addition, EMCP is committed to evaluating and pilot-testing technologies which improve Enrollee self-management and reduce Emergency Department and inpatient costs. EMCP has had preliminary discussions with ACOs about adoption and funding of innovative technologies in the BH CP program. EMCP is currently evaluating technologies which have the following characteristics: address both psychiatric and complex medical conditions; cost $50-60 per member per month (which means they are cost-effective if they save one Emergency Department visit per year and/or one hospital day); and they have robust data systems which can be integrated with Electronic Health Record systems. EMCP proposes to implement the remote-monitoring technologies in Budget Periods two and three. If the results of the NIMH-funded study continue to show promise, EMCP will deploy the Phillips Telestation to 20 BH CP Enrollees each year at a cost of $720/Enrollee/year. EMCP will fund half the costs of this technology and will ask ACOs to contribute the other half.

7.3 E Personnel and Staffing

Describe proposed staffing plan to perform CP Contractor Responsibilities and fully implement required scope of CP Supports and administrative aspects of the Contract

Members of EMCP have extensive experience developing new programs that must be launched and staffed within short time frames. For example, in 2009, Bay Cove and Vinfen each implemented the newly awarded DMH CBFS programs on time, re-designing jobs of existing

employees and hiring hundreds of new staff. As well, Bridgewell is an organization embedded in the community and has experience developing new programs as needs arise. In March 2017, in response to the opioid epidemic, Bridgewell partnered with North Shore Medical Center to place Recovery Coaches in the Emergency Room to engage and support people presenting for overdoses. The urgent nature of the program required a quick start hiring on-call Recovery Coaches and case managers and developing workflows with the hospital system.

EMCP's care teams will be informed by this collective experience and employ an outreach model where in each care team will have an office as a home base though will accomplish much of their work outside the limits of an office: in an Enrollee's home or preferred location in the community, in some cases on the street, very often at locations of other community support and social services providers as well as ACO/MCO medical and behavioral health clinics. Decisions on care team locations and the number of Enrollees assigned to each team will be based on several factors: the number of attributed Enrollees who are existing clients and ACO/MCO Assigned Enrollees, where Enrollees live, location of the referring ACO/MCOs, accessibility of physical office location to key roads and practical considerations as related to the most cost effective design.

As discussed in **Section 7.2 B,** key administrative functions will be performed by a small ECMP central management team, and others will be delegated to either Bay Cove or Vinfen.

1. Provide organizational chart that identifies personnel, senior managers, and other staff by title to be assigned to accomplish Contractor Responsibilities described in Attachment A

See **Attachment 4:** EMCP Organizational Chart, **Attachment 5**: EMCP Organizational Chart of Contracted Services; and **Attachment 6:** EMCP Care Team Organizational Chart.

2. **Sample staffing model for number of Engaged Enrollees in each Service Area, including number of FTEs for supervision, administration, and Care Management/Coordination**
EMCP has developed care team models that will be adapted by each Member and support from 250 to 450 Enrollees per team. Each Member will hire or appoint a staff person to serve as Director of Care Coordination to provide oversight for their respective care teams of the BH CP program. Bay Cove and Vinfen will each hire into this role, (role of Program Director), and will each hire an Assistant Director to partner with the Program Director in providing direction supervision to care team across three regions. Bridgewell will appoint their existing Director of Clinical Services to serve in this role, as they will serve one region only.

Larger teams will be supervised by a CP Team Leader while smaller teams will be combined to share administrative and supervisory staff. Each team will consist of Clinical Care Managers, Recovery Support Navigators, and Care Coordinators, each carrying a caseload of 45 to 50 Enrollees. Clinical Care Managers will be licensed clinicians including licensed mental health counselors (LMHC), licensed registered nurses (RN), licensed independent clinical social workers (LICSW), licensed marriage and family therapists (LMFT), or licensed alcohol and drug counselors I (LADC I). See **Attachment 6:** EMCP Care Team Organizational Chart.

The table below summarizes the number of FTEs for each position that will be required when EMCP Enrollment is at its designed Capacity (5,540 Enrollees). Staffing will be adjusted based

on number of Enrollees as care teams are starting up. Anticipating a high volume of referrals in the first 18 months of the program, EMCP will develop dedicated Assessment Teams responsible for the initial outreach, engagement, consent, assessment and care planning work with Assigned Enrollees. As referral volume decreases and EMCP's designed Capacity is reached, separate Assessment Teams may no longer be necessary, and Assessment staff will join Care Teams.

Position	**Number of FTEs** [assumes 5,540 Enrollees]
Director of Care Coordination	2
Assistant Director of Care Coordination	2
Team Leader	11.7
Clinical Care Manager (RN)	23.5
Clinical Care Manager (LMHC, LICSW, LMFT)	15.3
Care Coordinator (Health Outreach Worker)	49
Care Coordinator (Recovery Support Navigator)	18.9
Program Coordinator (Administrator)	10.5
Total	**132.9**

For administrative functions, EMCP will employ a central management team to provide EOHHS contract oversight and manage central operations such as intake of Enrollees, referral to care teams, grievances, marketing, ACO/MCO contract development, and management of care team contracts. The EMCP management team will include an Executive Director, Director of Quality and Analytics, Director of Operations, CP Project Manager, Intake Specialist, and Customer Service Specialist. The central management team will also include a fraction of a Nurse Practitioner and Psychiatrist to serve as Consultants to our Care Teams with regard to clinical risk cases. The central management team will contract with Bay Cove for financial services and human resources, and with Vinfen for information technology services, website and quality management. The staff positions required for those contracted services are detailed in **Attachment C**: Budget Narrative.

3. Describe recruitment plans, including timelines to recruit staff for any personnel positions not currently filled, job descriptions and qualifications for each personnel position. Job descriptions shall contain information regarding education, background, qualifications, credentials, and relevant recent work experience

Each Member of EMCP has a professional Human Resources Department responsible for meeting the recruitment needs across service types while promoting staff retention. The Members have a combined workforce of more than 5,800 employees. Each has extensive experience at both "staffing up" new programs and new service types, and sustaining a capable, active and engaged workforce.

As soon as EMCP learns of its BH CP award, the Members will launch both internal and external recruitment plans in order to fill Care Coordination management positions such as Program Directors and Team Leaders, as well as key administrative and programmatic positions. With job descriptions developed and finalized in advance (**Attachment 7:** Care Team and Contracted Services Job Descriptions), recruitment of these key positions will be in full swing by November 2017. We will prioritize these leadership positions so that they may in turn hire their respective care team members. The following is the timeline for filling key positions:

Recruiting	Start Date	Key Positions
Sept 2017 – Mar 2018	Nov 2017 – Mar 2018	EMCP Executive Director, Directors of Care Coordination (Bay Cove and Vinfen), EMCP Project Manager, IT Systems Administrator, Financial Analyst
Dec 2017 – Apr 2018	Feb 2018 – Apr 2018	EMCP Director of Operations, EMCP Director of Quality & Analytics, Assistant Directors of Care Coordination (Bay Cove & Vinfen); Care Team Leaders (7), CCIT Systems Support
Mar 2017 – Jun 2018	May 2018 – Jun 2018	Assessment Team Managers (Bay Cove and Vinfen); EMCP Nurse Practitioner and Psychiatrist; Clinical Care Managers (7), Care Coordinators (7), EMCP Quality Manager, EMCP Intake Specialists, EMCP Customer Service Specialist

Our recruitment campaigns will include widespread advertising: outreach to career fairs, trade organizations, community based organizations and cultural centers; college and certification program outreach; and by sourcing through online resume mining. Our campaigns will also benefit from sourcing internally. Each Member promotes a robust employee referral program as well as a commitment to promoting from within. Each has demonstrated experience in launching new programs through the promotion of qualified candidates and expects to make the most of this practice to staff CP care teams. This multi-pronged approach to recruitment will yield both internal and external candidates in a more timely way. And with the ongoing support of human resources, candidates will be interviewed with the goal of moving them through the process quickly. Drug testing, background and reference checks will be expedited for selected candidates. Our goal will be to have official offers made within 4-6 weeks of initial screening, pending second round interviews and how quickly drug testing, background and references checks can be secured. Through multi-faceted recruitment approaches and expedited hiring processes, we will ensure for sufficient staffing capacity to be hired, oriented and trained so that we can effectively begin outreach / engagement activities on June 1, 2018.

4. Describe strategy for recruiting and hiring staff from the cultural and linguistic communities they intend to serve

Members of EMCP are committed to hiring staff that are reflective of those we serve. To exemplify this principle, in April 2017 Vinfen launched a new recruitment and retention campaign "My Job, My Community, My Vinfen." This tagline was selected not by Vinfen leadership, but by direct care staff and front line managers. Extensive focus group review further reinforces that our employees identify strongly with the programs, clients, and communities with which they work. As such, EMCP will target its advertising specific to the geographic and demographic communities our Community Partner services will reach in order to meet our staffing needs.

As noted above, each Member will use a variety of strategies and sources to recruit and on-board personnel needed, including some combination of internet advertising, social media, print media, billboards, and advertisements on public transit. As in past campaigns, Members will use newspapers, websites, and radio spots that reach ethnic and cultural communities of those we serve; attend Boston's Annual Diversity Employment Day Career Fair as well as Boston's Bilingual and Diversity Job Fair; advertise in print media such as Bay Windows; and outreach to cultural organizations such as the Haitian Multi-Service Center and to colleges and universities

with diverse student populations. Through these efforts, we intend to hire staff who are bilingual and bicultural to match the needs of targeted populations.

5. Describe proposed training, orientation plans and modules for staff

As noted earlier, each Member of EMCP has a centralized HR Department serving a combined workforce of more than 5,800 employees. Each Member holds new employee orientation weekly. New employee orientations are comprehensive and inclusive of: agency history and mission, organizational structure, overview of populations served, agency policies and procedures, employee relations, professional ethics, diversity, communication systems, culture of caring, and training and advancement opportunities. Mandatory trainings such Compliance, Universal Precautions, and Sexual Harassment are included in this initial new employee orientation.

After completing new hire orientation, employees begin their program-specific orientation and training. While each Members' Training department is staffed with full time trainers, each also benefits from a cadre of Subject Matter Experts - operational staff within each service type that offer specialized training complimentary to the training department courses. For BH CP teams, program specific modules will include the following required trainings:

- Overview of the Community Partner model of integrated care management including care coordination functions, care transitions, and medication reconciliation
- Comprehensive Assessment process, PCTP development and implementation
- MassHealth state plan LTSS services and eligibility criteria, choice counseling and person centered care planning
- Independent living movement and recovery principles including accessibility and accommodations
- Orientation to Enrollee Engagement strategies including Motivational Interviewing as well as Promising Strategies as outlined in National Health Care for the Homeless Council and guidelines offered through SAMSHA –HRSA's Center for Integrated Health Solutions
- Orientation to Evidence Based Practices including Cognitive Behavioral Therapy (CBT), SAMSHA Integrated Treatment, Dialectical Behavior Therapy (DBT), Illness Management and Recovery (IMR), WRAP for Addictions, and Trauma Informed Care
- Orientation to Health and Wellness Coaching tools including Whole Health Action Management (WHAM), Wellness Recovery Action Plan (WRAP), Program to Achieve Wellness (PAW), and SAMSHA's Eight Dimensions of Wellness
- Overview of Health Disparities and Social Determinants of Health
- Cultural Competencies overview
- Enrollee Rights and Protections
- Conflict of Interest policies
- Orientation to Care Coordination Information Technology (CCIT) system

6. Describe staff retention strategy

EMCP Members have dedicated strategies for effectively promoting retention of talented personnel. The Members' collective experience validates that staff retention is highly correlated with Mission, as employees seek to make a meaningful contribution, to make a difference, and to positively impact people served. Leadership teams value their employees and the day to day contributions they make to those served. Retention strategies employed by each Member promote such cultures of dignity and respect. They promote cultures of flexibility, of team work, and they embrace diversity. They enable employees to attend to both their professional

responsibilities and their commitment to home and family. They invite ongoing dialogue between management and direct care staff through a variety of avenues including direct care roundtables and town meetings with the CEO, suggestion boxes, and promotion of an open door policy. Formal retention strategies employed by each Member are outlined below:

Competitive wages within the Human Services Industry: Each Member continually assesses how its wages compare to those of its competitors. Through careful financial stewardship, each has been able to remain competitive within the industry.

Outstanding Employee Benefits: Employees of each Member regularly cite generous benefits as something important to them and as something that factors into their decision to maintain their tenure. Each Member offers a package that supports an employee's personal and family needs, and may include any combination of: health insurance, dental insurance, vision; retirement plan; 403(b) Tax-deferred annuity plan; generous vacation, sick, holiday and personal time; life insurance; Long-term Disability Insurance; Commuter Benefits; Employee Assistance Program; Flexible Spending Plans; Professional Development and Educational Assistance; Compassionate Relief and Natural Disaster Programs.

Training / Staff Development: Each Member promotes and embodies the principles and practices fundamental to Learning Organizations. Each is committed to doing their part to promote the development of our workforces, personally and professionally. Whether through refresher or recertification courses or newly developed classes to promote evidence based practices, the Members' collective workforce is continually receiving the information they need to perform most effectively and advance in their careers. New Managers are offered training specific to the administrative functions of their new role while Basic and Advanced Supervisory Skill Trainings offer modules specific to becoming an effective supervisor; employee coaching, conflict resolution; diversity in the workplace; interviewing and hiring; and tough issues. All Employees are given the opportunity to attend external trainings, workshops, CEU's (as applicable) and conferences to further their professional development.

Employee Recognition: Each Member promotes employee recognition in a variety of ways. Sample Employee Recognition programs include: years of service awards, gifts (monetary or items); quality of care awards; monthly themed awards by job category; peer recognition programs; employee newsletters; scholarships; for employees pursuing higher education, fee reimbursements; holiday and seasonal celebrations highlighting staff contributions.

Effective Retention Strategies are particularly essential for long term growth at a time when the landscape of the human services industry is overwhelmed with challenges, from the consequences of over three decades of level funding, to high employee burn out rates, to losing a percentage of the workforce to higher paying opportunities in the for-profit world. With a balanced approach to recruitment and retention, EMCP Members are prepared to meet the scope and capacity of the Community Partner Program.

7.3 H Sustainability

EMCP will use DSRIP funds to develop the important capacities and infrastructure necessary to operate a BH CP program. The capacities and infrastructure that EMCP develops will serve to

sustain the program throughout the five year Contract Term and after. Certain investments will be tangible: a system to support care coordination, a data warehouse, and marketing materials including a website. Other investments will develop capacities: a workforce that is trained in care management for people with SMI/SUD; workflows for coordinating care across BH CP and ACO/MCO care teams; and a new organization that brings together three leading Community Based Organizations into a structured collaboration – Eastern Massachusetts Community Partners (EMCP). Below are specific capacities and structures that EMCP will develop to live beyond the five year term of the Contract:

- **ACO/MCO relationship development**: As described in **Section 7.3** J, EMCP will invest staff resources to develop relationships with ACO/MCOs in our service areas. The relationships needed to coordinate care for Enrollees go beyond a simple contract. EMCP will develop in collaboration with each ACO/MCO, specific protocols workflows, policies and procedures to address the areas of collaboration including: Enrollee referrals, notification of admissions, discharges and Emergency Department visits, Flexible Services processes, EHR data sharing to complete a Comprehensive Assessment and Person Centered Treatment Plan (PCTP), service arrangement and authorization protocols, and transitions of care.
- **Marketing to ACO/MCOs:** EMCP believes that the most important marketing work with ACOs/MCOS is the above-described relationship development work. In addition, EMCP will conduct trainings for ACO/MCOs, and will create a website and written materials.
- **Organizational structure to facilitate the collaboration of three Consortium Entities**: Each EMCP Member has invested, and will continue to invest, the time of key personnel of its Executive and Clinical teams to agree to a governance structure, operating agreement and key administrative functions in support of the BH CP program. To date, each Member's CEO, CFO, General Counsel, CIO, and Senior Vice Presidents of programs has invested significant time in developing the new organizational structures. Each Member has also devoted project management, business development and administrative staff to developing the EMCP structures and policies.
- **Workforce Development:** EMCP Members have existing workforces that perform care coordination responsibilities through CBFS and SUD case management programs, and care management / LTSS coordination through One Care Health Home programs. An additional 164 FTEs will be recruited by Members and trained to support the BH CP program. The new workforce will have a higher proportion of licensed clinical staff such as RNs, LICSWs and LMHCs as well as a higher proportion of Recovery Support Specialists than existing programs. Not only will this workforce be trained in the principles and practices of integrated care management, they will also be developing relationships with their ACO/MCO counterparts to better coordinate care and better serve Enrollees. Although Care Coordinators (CCs), Clinical Care Managers (CCMs) and Team Leaders are supported through the base PMPM ($180 PMPM and $250 PMPM for CBFS), DSRIP supports hiring staff in advance of having full caseloads and supports the BH Directors of Care Coordination in each Member in the Prep Budget Period.
- **Training curriculum**: EMCP will invest in the development of a training curriculum for all EMCP central and Member staff. CCs and CCMs will have more training than staff that do not have Enrollee contact. The curriculum will have all BH CP required elements. Some elements will be delivered by each respective Member and some elements that are unique to the BH CP program will be delivered centrally by EMCP central staff.

- **Enrollee Engagement:** Success of the program will be determined in part by the care teams' successes in engaging Assigned Enrollees. In addition to staff training and coordination with ACOs, EMCP will invest in the following Enrollee engagement strategies: development of an Enrollee Engagement Library of best practices, a quality improvement program that evaluates and iterates the Enrollee Engagement practices, a website and marketing materials for Enrollees, development of a video for Enrollees, and funds to be used to support initial engagement including paying for Enrollee transportation to a care team meeting or paying for snack or coffee at an initial meeting. Although Enrollee engagement will be required throughout the Contract term, more Engagement work will be required in the first two Budget Years to reach EMCP's Enrollment Capacity.
- **Resource directories and networks of community-based organizations:** EMCP care teams will build on existing community-based networks to develop directories for the BH CP program.
- **Care Coordination Information Technology (CCIT) and Data Warehouse systems:** EMCP will select, configure and develop a specialized care coordination system for the BH CP program. The CCIT will be used by all Care Coordinators and Clinical Care Managers to perform care management functions. It will also be used by financial, quality and programmatic staff to manage the performance of the program. The CCIT will be supported by a Data Warehouse that will store BH CP Enrollee data and will allow for aggregation of other data such as EHR data from ACOs and/or claims data from MassHealth and/or MCO/ACOs. DSRIP funds of over $650,000 over the five Budget Periods and the Preparation Budget Period will be spent on Information Technology solutions to support the development, implementation, and sustainability of the program.

Except where otherwise noted, all above described capacities and infrastructure will be supported through the investment of DSRIP funds. Some investments occur in the first few months of the program and other investments require sustained management over the five years of the program but will require less funding to sustain after the BH CP Contract term. For example, Information Technology requires an up-front investment of over $650,000. These costs are capitalized and spread across the five year Contract term. On an ongoing basis, EMCP's Program Budget proposes spending $270,000 per year to manage the IT systems which includes the cost of user fees, a User Support Specialist (one FTE) and Systems Administrator (one FTE). Another example is the ACO/MCO relationship development work. In the Preparation Period and Year one, several staff will be dedicated to documenting workflows, protocols, policies and procedures with ACO/MCOs but in later years as the BH CP program is more established, those staff will focus on contract management and program improvement work.

The DSRIP investments are detailed in **Section 7.3 G** Budget and Budget Narrative. EMCP's Budget proposes significant investments in infrastructure in the first few years. In later years, the base PMPM subsidizes more of the administrative functions needed to sustain the program with less support required from DSRIP funds. Sustainability of the BH CP program beyond the Contract Term will ultimately depend on EMCP's relationships with ACO/MCOs and whether the services that EMCP has provided lead to better health at reduced costs for the highest cost ACO Enrollees.

7.3 I Quality Management and Performance Monitoring

1. Describe Bidder's quality improvement program

EMCP plans to leverage the Members' years of experience managing robust Quality Management (QM) systems to develop and implement quality improvement programs targeting the integrated health domains in the new ACO system. Each EMCP Member employs QM systems which include: annual objectives derived from the organization's mission, long term goals, environmental scans, and data and needs identified from prior year performance; data collection across a wide range of behavioral and physical health measures, including process and outcome data across the domains listed in Attachment A of the RFR; processes for data analyses to shape the implementation and modification of annual and multi-year initiatives and improve performance and outcomes. Examples include:

- Prevention and Wellness: tracking and improving adherence to annual physical exams, and participation in wellness activities, such as walking clubs, fitness club participation, and smoking reduction programs.
- Chronic Disease Management: tracking claims and metrics data, and developing initiatives to improve blood pressure, weight and BMI, and management of diabetes with tracking of A1c levels.
- Behavioral Health/Substance Use Disorder: assessment of symptoms of psychiatric conditions, such as anxiety and depression, and functional measures of use of illegal or addictive substances such as K2 and opiods; and development of clinical and rehabilitation interventions to address these.
- Member Experience: satisfaction surveys from individuals served, as well as families; surveys are used to develop staff training or other interventions to improve satisfaction.
- Integration: tracking of data on both behavioral and health symptoms to develop and evaluate initiatives in which integrated services (such as the One Care Health Homes operated by Vinfen and Bay Cove) improve process, outcome, and value-based measures. Community tenure (healthy days in the community vs days in psychiatric or medical hospitals, or Skilled Nursing Facilitys, is measured, as this metric is increasingly recognized as a key indicator of effective integrated care and overall health.
- Avoidable Utilization: tracking avoidable Emergency Department visits, hospital readmissions within 30 days, and unnecessary home health services (e.g., multiple skilled nursing visits per day for simple medication administration).
- Engagement: tracking participants' adherence to attend scheduled appointments and participation in and approval of person-centered treatment plans.

EMCP's Quality Improvement Plan will be developed with the participation of all community partners, and input from partnering ACOs/MCOs, and will be submitted to MassHealth for approval. The Plan will then be implemented and evaluated monthly by each Member and the EMCP Quality Committee for the first year. If trends are stable, it will be evaluated quarterly thereafter throughout the Contract Term, and will be submitted to EOHHS on an annual basis. EMCP members' organizational leadership and Care Team staff will be responsible for collecting data and implementing initatives. Adherence to the plan ensure that EMCP is providing services that meet the expectations of Engaged Enrollees, partnering ACO/MCOs, and the requirements of MassHealth and CMS.

2. Describe at least one quality initiative the Bidder proposes to undertake in the first year including measures for success

In the first year of the award, EMCP will develop a quality management (QM) initiative to address *Care Coordination with a particular focus on Enrollee Engagement.* EMCP views care coordination and Enrollee engagement as essential to the success of the BH CP program.

A Care Team's success at engaging an Enrollee in the benefits of the Community Partner program can be measured by specific required milestones reached in the new partnership, as described in **Attachment A, Section 2.3 A**:

- Active engagement with Assigned Enrollees (AE): reaching the AE via phone, in-person or electronic means; completing an in-person visit with AE; providing AE with information on the BH CP program
- Confirming an Enrollee's interest in the new services through a signed participation form
- Completing, in partnership with an Enrollee, a Comprehensive Assessment (CA) that will inform the Enrollee's Care Plan goals
- Partnering with the Enrollee and their designated team in the development of Person Centered Treatment Plan (PCTP)

Engagement: The EMCP QM program will include documentation of each step of the Enrollee engagement process to understand which steps are being completed successfully, when they are completed, and where there are challenges. Care Coordinators (CC) and Clinical Care Managers (CCM) will document in Care Coordination Information Technology (CCIT) each step in the engagement process including attempts, contacts made, provision of information on the BH CP program, signing the participation form, Comprehensive Assessment completion and PCTP completion. Care Teams, on a weekly basis, will identify Enrollees who are difficult to engage, and will plan additional actions to improve engagement using tactics from a developing EMCP Engagement Strategies library. Based on the Members' significant collective experience prior to the start of the BH CP program, EMCP will develop a Library of Engagement Strategies by population to be continuously expanded and refined throughout the CP program. Care Teams, Members, and the EMCP QM Committee will review overall performance in Enrollee Engagement, as well as relative successes in using Engagement Strategies for targeted populations.

Timely completion of CA and PCTP: The EMCP Year One QM program will also track timely completion of the CA and PCTP. EMCP's CCIT will contain alerts that notify the Care Coordinator and the Care Team Leader about upcoming documentation deadlines. Delays in the completion of the Assessment and development of the PCTP will be documented in the CCIT system along with the reason for the delay. QM processes at the Care Team, Member, and EMCP level will review these data monthly and, as needed, EMCP will develop and implement initiatives to improve timeliness and completion of CAs and PCTPs. These data will also be reviewed for their relationships with outcomes and Enrollee experience over the entire Contract Term.

Care management and care coordination outcomes: EMCP Care Teams will also receive detailed productivity reports containing data from the CCIT specific to Care Management and Care Coordination outcomes. These weekly reports will be used by the Care Teams to identify gaps in services and requirements. As noted above, the data will also be reviewed monthly by the EMCP QM Committee to identify areas or Care Teams needing improvement and to inform process improvement activities.

EMCP anticipates that within the First Budget Year, ACOs will provide claims data to BH CPs. QM activities will use Claims data to refine its care coordination activities to ensure it is adequately targeting the highest users of acute care services, individuals with high pharmacy costs, those who have not seen a PCP in over one year or those who inconsistently refill medications.

3. Describe functions of the Bidder's quality management committee including the composition and reporting structure within the Bidder's organization

EMCP will establish a Quality Management (QM) Committee chaired by Vinfen's Vice President of Quality and Compliance. Membership of the Committee will consist of the Executive Director, Deputy Director and Program Manager, the Directors of Quality Management for each Member, and those serving as Director of Care Coordination for each Member. The QM Committee will meet monthly for the first budget period, then at least quarterly thereafter and will report to EMCP's Board of Directors. EMCP may determine more frequent meetings are needed for the first 1-2 years of the contract. The QM Committee will be responsible for the establishment, maintenance and continuous review of the Quality Improvement Initiative as well as the ongoing review of reports on all Quality Measures. The Executive Director of EMCP will: conduct monthly reviews of quality data with ECMP and Members' staff; engage in management actions to improve data as needed; participate in the QM Committee, and report on actions taken to improve processes and outcomes as planned with the Committee.

EMCP will collaborate with EOHHS, and with ACOs as needed, to establish performance benchmarks for all the Quality Measures. EMCP will review the Quality Score and a DSRIP Accountability Score detailed data from EOHHS for each Budget Period. All Quality Measures, including the claims-based measures, chart review measures, and member care experience surveys across the seven quality domains, will be reviewed by the program leaders for each Care Team, Member, and the EMCP QM Committee. Although Budget Period one and two are "pay-for-reporting," EMCP will implement improvement plans for any domain area that is trending or falls below the "attainment threshold," and will analyze reasons for all preventable Emergency Department visits and all cause readmissions in preparation for Budget Period 3 Outcomes Based Payments. The QM Committee will review the assigned achievement points as well as the overall Domain score in each category against the "attainment threshold" and "excellence benchmark" set by EOHHS as well as the overall Quality Score. For any domain that falls below the attainment threshold, EMCP will conduct a review and determine a plan of action to implement needed improvements. Since the DSRIP score is in part based on improvements from the previous Budget Period, close monitoring of progress will be imperative to maximize possible Improvement Over Self Points. In the event that EMCP does not achieve a 100% DSRIP Accountability Score, EMCP will provide EOHHS with a corrective action plan that includes steps to regain any at-risk funds.

7.3 J Coordination with ACOs and MCOs

1. Describe how CP's skills, expertise, and value will be communicated to ACOs and MCOs
Eastern Massachusetts Community Partners (EMCP) recognizes that to be successful in serving Enrollees in the BH CP program, it is important to develop robust coordination with ACOs and MCOs resulting in better care for people with SMI/SUD. To that end, EMCP Members have

reached out to all fourteen ACO/MCO bidders in EMCP's proposed service area (Greater Boston, Northern and Southern regions) to commence a planning process. To date, EMCP Member leaders have had at least one meeting with eleven of the fourteen ACO/MCO bidders. Additionally, Member leaders have met with four regional entities that are part of larger ACO bidding entities. EMCP views all initial ACO meetings as the first step in a longer planning process that will culminate in contracts by March 1, 2018.

EMCP uses the following planning process to develop ACO/MCO relationships and contracts:

Information gathering: This phase involves one or more meetings to 1) connect EMCP program leaders with key ACO/MCO clinical and business leaders; 2) provide background information on the BH CP program; 3) obtain information from the ACO on population, care management approach, information systems, plans for flexible services funds, identify BH and SUD service gaps in the region (e.g. outpatient mental health, alternatives to inpatient hospitalization, detoxification); 4) provide information on EMCP's care management experience and approach, BH and SUD service offerings, and current population served.

Case reviews: EMCP will promote the review five to ten cases of current shared clients/patients to develop an understanding of the specific services EMCP and ACO each provide and identify service gaps, redundancies and opportunities for improved coordination.

Roles, responsibilities and workflows: EMCP will promote agreement and alignment on each entity's roles and responsibilities, document workflows and points of coordination.

With one Greater Boston ACO bidder, EMCP has begun a pilot program to implement the program elements of the BH CP program for four EMCP clients who are also primary care patients of the ACO bidder. The pilot program serves to develop relationships between the key points of contact at the BH CP and ACO/MCO Bidders to promote the development of a contract that accurately reflects the roles and responsibilities of each organization so that EMCP and ACOs will be prepared to go-live with a larger program in Spring 2018. Specifically, the pilot program tests the comprehensive assessment and care plan that EMCP has developed for the BH CP program; designs workflows; and defines roles for EMCP care team staff and ACO primary care, psychiatry and care management staff. EMCP has proposed pilot programs with additional ACO/MCO bidders in the Northern, Southern and Greater Boston region and plan to launch those this summer.

2. Describe branding and marketing plans to be implemented with ACOs and MCOs
As described above in **Section 7.3 J.1**, EMCP's marketing will start with meetings with ACOs. In those meetings. key points of contact will be identified within the ACO, MCO and, when relevant, the BH management contractor such as Beacon or MBHP. We will conduct presentations for the key points of contact within the ACO or MCO to ensure that all are aware of the BH CP program and the role that EMCP plays in supporting patients with SMI/SUD.

ECMP will develop its own brand including logo, letterhead, and style templates. This brand will be used to support the in-person relationship development work. EMCP will develop the following types of media: a website, PowerPoint presentation, succinct leave-behind materials

for the key audiences at ACO/MCOs, and collateral materials such as pens or magnets. EMCP will also develop a video targeted to either the ACO audience or potential Enrollees.

3. Describe strategy to engage and collaborate with multiple ACOs and MCOs in the Services Areas for which you are bidding

EMCP will continue with the planning process described in **Section 7.3.J.1** to develop relationships with all ACO and MCO bidders in the Greater Boston, Northern and Southern regions. EMCP will develop pilot programs with two additional ACO/MCO Bidders that have expressed interest in doing so beginning June 2017.

EMCP will seek to develop care teams oriented to an ACO whenever possible. Exceptions will be made where there are existing relationships or geography outliers. This structure will promote and facilitate relationship and communication between the BH CP care team and the ACO's clinical staff. This structure will recognize that although many aspects of the BH CP program are be standard, some elements may need to be customized to work with a particular ACO.

4. Describe strategy for conflict resolution, should any conflicts arise between the Bidder and an MCO or ACO

In that the MassHealth ACO and BH CP program initiatives bring entities together into new types of relationships, there are several areas that have the potential for conflict: overlap in care coordinator roles, difference in the comprehensive assessment or care plan formats, differences in Information Systems used for documentation of care coordination activities, and difference approaches to use of flexible services. The most important strategy for conflict resolution is prevention. Most conflicts arise when roles, responsibilities and expectations have not been clearly defined. EMCP will invest time in developing contracts and operational relationships with ACO/MCOs prior to March 1, 2018 to avoid conflicts as much as possible. In addition, EMCP will develop regular coordination meetings with ACOs to check in on our work together and will outline escalation paths for conflicts that occur in the field.

We have found that, to date, there is uneven information among ACO/MCO Bidders about the BH CP program. The extent to which all ACO/MCO and BH CP Contractors can be provided the same information on program design from MassHealth will serve to prevent potential conflicts. With that said, EMCP has been providing ACO/MCO bidders with BH CP program documents in introductory meetings to ensure that we are starting with the same program assumptions.

Community Partner Program Budget Report

			Community Healthlink					
Program Revenue		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
Estimated Enrollees- Start of Period (All Enrollees)			200	1,160	2,560	2,680	2,680	
Estimated Enrollees - End of Period (All Enrollees)			1,080	2,440	2,680	2,680	2,680	
Estimated Enrollees - Monthly Average (excl CBFS enrollees)			505	1,603	2,490	2,500	2,500	
Estimated Enrollees - Monthly Average (CBFS enrollees only)			180	180	180	180	180	
Estimated Program Revenue (excl CBFS enrollees)			$ 636,300	$ 3,462,480	$ 5,378,400	$ 5,400,000	$ 5,400,000	$ 20,277,180
Estimated Program Revenue (CBFS enrollees only)			$ 315,000	$ 540,000	$ 540,000	$ 540,000	$ 540,000	$ 2,475,000
Total Estimated Program Revenue			**$ 951,300**	**$ 4,002,480**	**$ 5,918,400**	**$ 5,940,000**	**$ 5,940,000**	**$ 22,752,180**
At- Risk Withhold Rate				0%	0%	0%	0%	
Withhold funds				$ -	$ -	$ -	$ -	$ -
Revenue for Operations			**$ 951,300**	**$ 4,002,480**	**$ 5,918,400**	**$ 5,940,000**	**$ 5,940,000**	**$ 22,752,180**
	Program Expenses	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
1	**Salary**	$ 193,439	$ 743,692	$ 2,140,963	$ 2,635,541	$ 2,686,822	$ 2,762,308	$ 11,162,765
2	**Fringe**	$ 46,425	$ 178,486	$ 513,831	$ 632,530	$ 644,837	$ 662,954	$ 2,679,064
	Total Personnel Costs	$ 239,864	$ 922,178	$ 2,654,794	$ 3,268,071	$ 3,331,659	$ 3,425,262	$ 13,841,828
3	**Training & Professional Development**	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	**Travel**		$ 25,920	$ 113,400	$ 153,036	$ 156,097	$ 159,219	$ 607,672
5	**Equipment**		$ 6,975	$ 12,600	$ 14,600	$ 15,038	$ 15,489	$ 64,702
6	**Supplies**	$ -	$ 25,554	$ 74,446	$ 66,662	$ 66,022	$ 68,004	$ 300,688
7	**Contract Services** (consulting, professional)	$ -	$ 10,851	$ 14,468	$ 15,192	$ 16,711	$ 17,546	$ 74,768
8	**Software licensing**		$ -	$ -	$ -	$ -	$ -	$ -
9	**Telecommunications**		$ 14,445	$ 32,370	$ 37,833	$ 38,968	$ 40,136	$ 163,752
10	**Occupancy** (rent, utilities, maintenance)	$ -	$ 79,413	$ 204,600	$ 248,700	$ 271,755	$ 274,473	$ 1,078,941
11	**Other**	$ -	$ 157,055	$ 423,836	$ 531,306	$ 632,505	$ 633,984	$ 2,378,686
	Total Direct Costs	$ 239,864	$ 1,242,391	$ 3,530,514	$ 4,335,400	$ 4,528,755	$ 4,634,113	$ 18,511,037
12	**Indirect Cost/Administrative Overhead** **13.6%**	**$ 32,622**	**$ 168,965**	**$ 480,150**	**$ 589,614**	**$ 615,911**	**$ 630,239**	$ 2,517,501
	TOTAL EXPENSES	$ 272,486	$ 1,411,356	$ 4,010,664	$ 4,925,014	$ 5,144,666	$ 5,264,352	$ 21,028,538
	Surplus/Shortfall	*$ (272,486)*	*$ (460,056)*	*$ (8,184)*	*$ 993,386*	*$ 795,334*	*$ 675,648*	*$ 1,723,642*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Program Mananger	$ 85,000.00	0.25	6	$ 10,625
Program Director	$ 75,000.00	1.00	6	$ 37,500
RN	$ 63,600.00	4.00	2	$ 42,400
LPN	$ 55,000.00	3.00	1	$ 13,750
Care Coordinator	$ 37,000.00	15.00	1	$ 46,250
LPHA	$ 54,996.00	3.00	2	$ 27,498
Intake Coordinator	$ 39,996.00	1.00	2	$ 6,666
Admin Assistant	$ 35,000.00	1.00	3	$ 8,750
				$ -
Total Salary (Program Budget Line 1)		**28.25**		**$ 193,439.00**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 193,439.00	24%	$ 46,425
Total Fringe (Program Budget Line 2)			**$ 46,425**

Total Personnel*	**$ 239,864**

* Should align with Personnel Costs row in Program Budget

Program Manager: Administrative direction of the program
Program Director: Directly responsible for the day to day program management and overall staff supervision
Registered Nurse: Responsible for team's nursing functions
Care Coordinators: Provide care management including outreach, engagement, assessment, care planning, and community connection
LPNs: Provide care management including outreach, engagement, assessment, and community connection in addition to medication reconciliation under the supervision of an RN.
Licensed Clinical Supervisor: Team leader, responsible with Director for hiring, supervision, assignment of enrollees
Intake Coordinator: Responds to referrals, makes outreach calls, tracks referrals, with supervisors assigns referrals
Administrative Assistant: Provides administrative support to management and staff

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Total Training and Professional Development			

	A	B	C	D	E	F
48			**(Program Budget Line 3)**			

Provide a description of each Training and Professional Development line item included in the table above:

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
			Total Mileage	

Travel Expense Description	Cost
Total Mileage	$ -
Parking and tolls	
Public transportation	
Enrollee travel	

	A	B	C	D	E	F
95	**Total Travel**					
96	**(Program Budget Line 4)**	**$ -**				

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

Row 5 - Equipment

	Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost
118				
119				
120				
121				
122				
123				
124				
125	**Total Equipment (Program Budget Line 5)**			

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Total Supplies (Program Budget Line 6)			

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost

	A	B	C	D	E	F
237						
238				**Total Software Licensing**		
239				**(Program Budget Line 8)**		

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

	Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
273				
274				
275				
276				
277				
278				
279			**Total Telecommunications**	
280			**(Program Budget Line 9)**	

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent			$ -
Utilities			$ -
Repair and Maintenance			$ -
			$ -
			$ -
Total Occupancy (Program Budget Line 10)			

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

Row 11 - Other

Other Direct Expense Description	Cost
Total Other (Program Budget Line 11)	

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	**13.60%**	**$ 32,622**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

13.6% is CHL's approved Administrative Overhead rate.

Community Partner Infrastructure Budget Report

		Community Healthlink						
Infrastructure Investment Funding		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
	PMPM Infrastructure Rate		$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
	Engaged Enrollees		1,080	1,080	2,440	2,680	2,680	
	Estimated Infrastructure Funds		$ 756,000	$ 1,115,208	$ 1,507,627	$ 1,460,064	$ 1,263,245	**$ 6,102,144**
	At- Risk Withhold Rate			25%	44%	63%	81%	
	Withhold			$ 278,802	$ 663,356	$ 919,840	$ 1,023,228	**$ 2,885,227**
	TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 756,000	$ 836,406	$ 844,271	$ 540,224	$ 240,017	**$ 3,666,917**

	Infrastructure Investment Projects		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
	Technology								
1	**IT Staffing including Fringe**								**$ -**
2	**Development Adaptation of EHR and/or Care Management System**		$ 66,000	$ 125,280	$ 65,280	$ 65,280	$ 35,280	$ 35,280	**$ 392,400**
3	**Technology for Service Delivery**		$ 47,128	$ -	$ -	$ -	$ -	$ -	**$ 47,128**
4	**Other Technology Expenses**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Technology		$ 113,128	$ 125,280	$ 65,280	$ 65,280	$ 35,280	$ 35,280	**$ 439,528**
	Workforce Development								
5	**Workforce Development staffing including Fringe**		$ 4,591	$ 10,356					**$ 14,947**
6	**Recruitment Expenses**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
7	**Training Expenses**		$ 10,000	$ 6,000	$ 20,000	$ 20,000	$ 20,000	$ 4,000	**$ 80,000**
8	**Retention Expenses**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Workforce Development		$ 14,591	$ 16,356	$ 20,000	$ 20,000	$ 20,000	$ 4,000	**$ 94,947**
	Business Start Up Costs								
9	**Office Equipment (PBP & BP1 only)**		$ 5,972						**$ 5,972**
10	**Office Furniture (PBP & BP1 only)**		$ 22,500	$ 20,250					**$ 42,750**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**		$ 272,486	$ 460,056	$ 8,184	$ -			**$ 740,726**
	Total Business Start Up Costs		$ 300,958	$ 480,306	$ 8,184	$ -	$ -	$ -	**$ 789,448**
	Operational Infrastructure								
12	**Operation Staffing including Fringe**		$ -	$ 37,917	$ 65,000	$ 68,000	$ 70,000	$ 72,000	**$ 312,917**
13	**Other Operational Expenses**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Operational Infrastructure		$ -	$ 37,917	$ 65,000	$ 68,000	$ 70,000	$ 72,000	**$ 312,917**
14	**Indirect Cost/Administrative Overhead Rate**	13.6%	$ 21,242	$ 27,173	$ 20,438	$ 20,846	$ 17,038	$ 15,134	**$ 121,871**
	TOTAL INVESTMENTS		**$ 449,919**	**$ 687,032**	**$ 178,902**	**$ 174,126**	**$ 142,318**	**$ 126,414**	**$ 1,758,711**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary			$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Development Costs	$ 66,000.00

	A	B
34		
35		
36		
37		
38		
39	**Total Development and Adaptation of EHR and Care**	
40	**Management System**	$ 66,000.00
41	**(Infrastructure Budget Line 2)**	

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

CHL will engage a contractor to develop a custom care management to seamlessly interface with the organization's Electronic Health Record.

508Tech will work with Community Healthlink (CHL) to customize the 508Tech hosted (SaaS) solution and allow CHL to meet their EOHHS and ACO contract requirements as well as fulfilling their Community Partner compliance, analytics and interoperability requirements. This custom design will allow CHL to get exactly what they need to maximize their reporting. and interface with their health record system.

508Tech has over 20 years' experience on staff in technology, software development and clinical. 508Tech has a proven track record with its emergency services triage software solution, client and staff scheduling software and other consultation services.

330 hours of work on original programming @ $200 per hour = $66,000

Row 3 - Technology for Service Delivery

Description of Expense	Cost
Laptops	$ 33,600.00
Portable Printers	$1,500
PC's and desk printers	$ 5,400.00

	A	B	C	D	E	F	G
67	Ipads	$ 3,978.00					
68	LCD flat screen and mount	$2,650					
69							
70	**Total Technology for Service Delivery**	**$ 47,128.00**					
71	**(Infrastructure Budget Line 3)**						
72							

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

This is a new program that will have all new staff so equipment will be purchased that is compatible with the new EHR and that can be used in the field for assessments and treatment planning. We will purchase ***24 laptops*** *for the RN, LPHA and Care Coordinator staff (including LPNs). These are $1400/per person. Price based on current purchases of similar equipment*

Portable Printers*. The program will purchase 5 portable printers so that staff can print documents in the field and leave a copy with the Enrollee or with a provider. $300/ per printer* Based on the *average cost for HP OfficeJet 200 Portable Printer with Wireless & Mobile Printing with cartridges.*

4 Desktop computers with screens and printer *will be purchased for intake worker, Administrative Assistant, Program Director and Director of Care Management $1350/per person based on current similar purchases.*

4 IPADS *that can be used for video translation and are compatible with our video translation service. $1000/per IPAD*

We will need to provide initial and ongoing training in a conference room and will purchase a ***an LCD flat screen*** *for that purpose.*

$2,500 for a 75 inch Sony Ultra HD and $150 for a wall mount totaling $2,650.

Row 4 - Other Technology Expenses

	Description of Expense	Cost
91		
92		
93		
94		
95		
96		
97	**Total Other Technology Expenses**	**$ -**
98	**(Infrastructure Budget Line 4)**	
99		

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
HR Recruiter	$ 29,620.00	0.25	6	$ 3,703
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0.25		$ 3,703
	Fringe rate	24.0%	Total Fringe	$ 889
Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)				**$ 4,591**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Six months of approximately 10 hours per week or 260 hours of dedicated recruitment time for the CP project. This will include posting of positions, screening and managing resumes, working with online recruitment resources, sending notifications to local schools and assisting with hiring process. This will assist the program in meeting its staffing requirements in a timely fashion.

Row 6 - Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses (Infrastructure Budget Line 6)	

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Row 7 - Training Expenses

Description of Expense	Cost
Training	$ 10,000.00
Total Training Expenses (Infrastructure Budget Line 7)	**$ 10,000.00**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

We are contracting with Center for Health Impact for 6 days of training. The Center has experienced trainers and developed curriculum. They currently hold a contract to train CHWs as well as medical interpreters. They will provide 6 days of training with a Facility member and CHW at each training; course materials, pre and post course assessments. General topics for the sessions:

Principles of Recovery
Introduction to Motivational Interviewing
Day 3 and 4 Systems thinking approach for Person-Centered Care and Transition across the Health Care Continuum
Days 5 and 6 Successful supervision of Care Coordinators

The training selected covers key topics for the Care Coordinators, nursing and LPHA staff. There are components focused on nursing around transitions of care and for supervision. Approximately 29 staff would attend the first 4 days of training. The supervision training would be for approximately 9 staff. The 5 managers would attend and in addition to the 4 RNs.
The training cost is $1541.67 per day
Curriculum customization 8 hours @ 93.75/ hour = $750

Row 8 - Retention Expenses

Description of Expense	Cost
Total Retention Expenses (Infrastructure Budget Line 8)	

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Business Start Up Costs - Prep Budget Period

Row 9 - Office Equipment

Description of Expense	Cost

	A	B
231	Copier	$ 5,972.00
232		
233		
234		
235		
236		
237	**Total Office Equipment**	**$ 5,972.00**
238	**(Infrastructure Budget Line 9)**	

Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were determined:

This copier is a a medium volume full color unit with copy, print, scan, staple and fax functions. The price was quoted from Toshiba who supplies our other agency copiers. This will be utilized by all administrative and all other staff.

Row 10 - Office Furniture

Description of Expense	Cost
18 smaller Desks	$ 9,000.00
9 larger desks	$ 8,100.00
27 desk Chairs	$ 5,400.00

	A	B	C	D	E	F	G
264	**Total Office Furniture**	**$ 22,500.00**					
265	**(Infrastructure Budget Line 10)**						
266							
267	***Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were***						
268	***determined:***						
269							
270	*This is the listing of basic furniture for the first three teams of our CP program. The Care Coordinators will be in cubicle type space*						
271	*with smaller desks. The prices were based on similar purchases through W.B.Mason.*						
272							
273							
274							
275							
276							
277							
278							
279							
280							
281							
282							
283	**Community Partner <u>Infrastructure</u> Budget Report - Operational Infrastructure - Prep Budget Period**						
284	**Row 12 - Operational Staffing including Fringe**						
285	**Position**	**Annual Salary**	**FTEs**	**# Months**	**Total**		
286					$ -		
287					$ -		
288					$ -		
289					$ -		
290					$ -		
291					$ -		
292					$ -		
293					$ -		
294					$ -		
295		Total Salary	0		$ -		

	A	B	C	D	E	F	G
296		Fringe rate		Total Fringe	$ -		
297	**Total Program Staffing including Fringe**						
298	**(Infrastructure Budget Line 12)**				**$ -**		
299							
300	***For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting***						
301	***the terms of the CP's contract:***						
302							
303							
304							
305							
306							
307							
308							
309							
310							
311	**Row 13 - Other Operational Expenses**						
312	Description of Expense	Cost					
313							
314							
315							
316							
317							
318							
319	**Total Other Operational Expenses**						
320	**(Infrastructure Budget Line 13)**						
321							
322	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms***						
323	***of the CP's contract and how the costs were determined:***						
324							
325							
326							
327							
328							

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**13.60%**	**$ 21,242.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

13.6% is CHL approved Administrative percentage.

	A	B	C	D	E	F	G
359							
360							
361							
362							
363							
364							
365							
366							

Community Partner Infrastructure Allocation Worksheet

	Insert Contractor Name Here						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 756,000	$ 836,406	$ 844,271	$ 540,224	$ 240,017	$ 3,666,917
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL INVESTMENTS	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Development and Adaptation of E.H.R/Care Management System	To be able to track client activity and run required reports	10/16/17	04/30/18	System is developed and CP is testing with client data Specifically, who in the CP is testing?	Able to enter client data, run reports, have activities counted and tickled			?			
Technology	Technology for Service Delivery	To have computer and printer equiptment for staff compatible with new HER	12/01/17	02/02/18	Equipment is purchased and set-up for all hired staff Which equipment and for how many staff?	Staff are able to enter client data into using computer equipment Is this evidence feasible by 3/31? They won't have Enrollees by then.			?			
Technology												
Technology												
Workforce Development	Workforce Development Staffing including Fringe	To hire 27 staff for CP program	10/16/17	04/30/18	Managers, administrative assistant, intake, RN and LPHAs are hired	Staff have been hired and oriented to CHL and the program						
Workforce Development	Training Expenses	For staff to have completed 6 days of training from Center for Health Impact	05/01/18	05/30/18	Staff will have completed 6 days of training from Center for Health Impact	Staff will show an increase in knowledge based on pre and post assessments						
Workforce Development												
Workforce Development												
Business Start Up Costs	Office Equipment	To have a copy, scanner, fax machine for use by the CP	12/01/17	05/30/18	The anticipated space for the team will not be ready until June 1, 2018 so copier will be delivered on this date so there are not multiple moving costs Then please move to 5/31 milestone and highlight evidence of success							
Business Start Up Costs	Office Furniture	To have desks and chairs for first cohort of staff	12/01/17	05/03/18	The anticipated space for the team will not be ready until June 1, 2018 so furniture will be delivered on this date so there are not multiple moving costs same as above							
Business Start Up Costs	Ramp-up Costs	To cover cost of staffing prior to the program start-up How is this different from recruitment goal in workforce development category?	01/01/18	05/30/18	This goal interfaces with recruitment. Staff for the first cohort should be hired by 4/30/18 with some staff starting in January 2018							
Business Start Up Costs												
Operational Infrastructure												
Operational Infrastructure												
Operational Infrastructure												
Operational Infrastructure												

BH Community Partner - Staffing Model

Insert Contractor Name Here

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	1080	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	1.6	*Total management oversight of BH CP*
3	Medical Director	0.05	*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs		
5	Clinical Care Managers (RN)	4	*Do not include FTEs listed in line 4*
6	Clinical Care Managers (LPHA)		*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders	3	*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff		*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	18	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)		*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists	1	
12	Administrative Support	1	
13			
14			
	Total FTE	28.65	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1 to 270	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	1 to 6	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff: In our model the team leaders/LPHA provides supervision to the care coordinators. The RN oversees the LPN work as required by their scope of practice.

Section 7.3: Initial DSRIP participation plan

A. Executive summary

CHL's goal in being a Community Partner provider is to support and coordinate services across the continuum of care for adults on MassHealth in the Worcester and Fitchburg-Gardner areas who suffer from serious mental illness and/or substance use disorders. We have proposed to provide this service in the Gardner area through Clinical and Support Options (CSO) as a Subcontractor because of their strong presence as an agency in that community.

As behavioral health and primary care providers, CHL and CSO are closely connected to the rural towns and to the cities of these communities. CHL has over 50 years of experience providing a continuum of primary care and behavioral health services including care coordination throughout the region. We know that both the BH and medical systems of care are complex, that our BH clients die on average 10-20 years earlier than the general population and that conditions of homelessness, victimization, poverty and social isolation negatively impact their ability to navigate and benefit from traditional care. Therefore, our CP staff, following best practices, will support individuals to navigate systems and will coordinate services so that our clients receive holistic, quality and preventative care. We believe our outcomes will show that clients report better health and quality of life. We believe our model will help to break down silos of practice and will address social determinants of health. Our hope is that through collaboration with ACOs, MCOs, Primary Care Practices and BH providers that we will create a system of truly integrated care and reduce or slow down the increase of health care cost.

We have designed CHL's CP to grow from 200 Engaged Enrollees on June 1, 2018 to a capacity to serve 2440 Engaged Enrollees by December 2019. We have mapped out a growth plan for each year of the project. Our plan assumes referrals of 200/month and an attrition rate of 40% (individuals we were unable to contact/locate after multiple attempts, those that declined the CP service and those who choose another CP provider, etc.) each month for Budget Periods #1 and 2. We have a predicted a stable caseload size for years 3-5.

Our CP model is to have multidisciplinary teams linked to specific BH or PCP practices. Each team is designed to provide care coordination for approximately 270 individuals. We will **begin in June 2018 with three teams** with a caseload capacity of 810 Engaged Enrollees. Two teams will cover Worcester and one team, North Central (with CSO staff located in Gardner and CHL staff in Leominster). We believe that being embedded in the practices, the Care Coordinators will have an increased ability to engage the Enrollees. They will have regular access to staff to obtain information for the Comprehensive Assessment or the Person-Centered Plan. They can share updates and outcomes of referrals and linkages and join in staff meetings.

Each team is led by a licensed BH clinician supervisor. Each team is staffed with one full time RN and 6 Care Coordinators. During year one the program is supported by a Full Time Program Manager, Administrative Assistant, Intake Coordinator and .05 Medical Director. In addition, the CSO team sited in Gardner will be supported by the CSO CP Director. We expect five Care Coordinators on each team to have caseloads of approximately 55-60. One Care Coordinator on each team will be an LPN. Each team will also have outreach specialist- Community Health Worker (CHW) - to carry a smaller caseload of more difficult-to- engage individuals. The RNs and Licensed Clinician will carry a caseload of 5-10. We will maintain an RN ratio of 1:270.

In Budget Period #2 (2019) we will hire four additional teams (two in January and two in May) with training and start-up costs funded by DSRIP. We will add a Nursing/Assistant Director and data/administrative support. The final team will be hired in 2020 and with that 8th team we will have reached the staffing necessary to provide Care Coordination services for approximately 2680 individuals. We will continue to have the capacity to both add staff to teams as well as to add full teams if the number of Engaged Enrollees exceeds 2680.

Our DSRIP budget plan for each year supports the following initiatives:

- The start-up of the eight teams over the first three budget periods: The Program Manager and Licensed Clinical Care Managers and RNs, will be hired in March and April 2018 so they are able to develop materials for ACOs MCOs and Enrollees, work on standard work formats for intake, engagement, assessment, treatment planning, care coordination, medication reconciliation, wellness and care transitions. These staff will meet key Stakeholders and establish communication protocols. DSPIP funds will support the first month of all Care Coordinators' and RN's employment with CHL (training) and portions of their salary for the next three-four months as caseloads build.
- The implementation of an EHR: DSRIP funds will be used toward costs related to our new EHR, Qualifacts. The EHR will allow Care Coordinators to communicate with all CHL programs through a single record. (Currently CHL uses three EHRs and has paper records). Qualifacts has significant reporting capacity, as well as tasking and messaging functions, alerts, and dashboard configurations. Qualifacts will be part of the DSRIP request beginning in Budget Period 1.
- The purchase of laptops/tablets and smart phones: This technology is necessary for staff to provide the Care Coordination service effectively in the field.
- DSRIP funding will be used in years 2-4 for a data analyst who will work with the team on our population health data and develop Quality Management initiatives geared to improve the wellbeing of our Enrollees based on the data we have collected.
- Funding will support IT consultation, training and support for both software and hardware.
- We are using funding to support training and CHW certification that will be provided by The Center for Health Impact.
- Purchase of equipment and furniture for new staff.
- Time of a Recruiter in the Prep time and Year 1.

The greatest challenge CHL has identified in our CP planning is work force development. We compete with hospitals, insurance companies and the State for trained, experienced human service and nursing staff. Already our HR team is utilizing our Quality Improvement tools of "Lean Thinking" to address recruitment challenges. Secondly, we acknowledge that there are still many unknowns. We look forward to participating in the "learning community" as CP providers, BH and PC providers along with the ACOs, MCOs, and EOHHS come together to provide coordinated integrated care for this vulnerable population. Finally, there are many assumptions in setting up budgets for 5 years. We will count on many forms of data, from ACOs and our EHR and from EOHHS to continually assess our plan and progress.

B. Supporting populations and community engagement

1. Community connections and collaborations

Community connections and linkages are at the core of Community Healthlink's (CHL's) services, and have been since our inception – so much so that this is reflected in our name. In both the Worcester Service Area and Gardner-Fitchburg Service Area, we maintain connections to a wide variety of other community entities, including other behavioral health organizations, health care entities, anti-poverty agencies, services for victims of domestic violence, legal services, housing and shelter providers, and more.

In the Worcester Service Area, we work closely with: LUK, Inc. (a behavioral health provider with whom we partner on four contracts); the YWCA of Central Mass., New Hope, and Pathways for Change (all providers of services for victims of domestic violence, dating violence, or stalking); Spectrum Health Systems (provides methadone maintenance for CHL clients); Ascentria Care Alliance (provides services to newly arrived immigrant and refugee clients); AdCare Hospital (provides inpatient substance abuse treatment); AIDS Project Worcester; the City of Worcester's Office of Human Rights and Disabilities; the Worcester Probate and Family Court; the Worcester Probation Department; the Worcester Police Department (who work closely with us to divert people in mental health crisis from jail); Worcester Public Schools; UMass Extension (nutrition trainings); Worcester County Continuum of Care; Central MA Housing Association (CMHA) and South Middlesex Opportunity Council. CHL works closely with and referred individuals to the Parent/Professional Advocacy League PPAL, the Recovery Learning Center (RLC), AA, Learn-to-Cope. and National Alliance on Mental Illness (NIMH). Genesis Clubhouse (and CHL' Westwinds in Fitchburg) are resources for our SMI clients looking for help in furthering education and developing work skills.

We have developed a referral network to assist with obtaining food and housing for our clients. We have posted the schedules of local food pantries and of the Salvation Army, Mustard Seed and Our Father's Table (Fitchburg) which serve hot meals. Additionally, the Center for Living and Working and Elder Services of Worcester provide LTSS for clients in need of those services.

We partner and work closely with Family Health Center of Worcester and Edward M. Kennedy Community Health Center the two Worcester Federally Qualified Health Centers. Staff work closely with Primary Care Providers within the UMass and Reliant systems as well as private PCPs. We regularly refer clients to South Bay, Arbor, Island Counseling and Multicultural Wellness and YOU, Inc. for specialized behavioral health services.

CHL has been a part of the fabric of North Central MA since 1957. In the Gardner/Fitchburg Service Area, we work closely with: Alternatives, Inc. and Bridge of Central MA (CBFS providers); Nizhoni Health Systems (short-term, in-home health care services); and Spectrum Health Systems, GAAMAH and Habit OPCO for SUD services. Through the Health Policy Commission we have contracts with both Heywood and Health Alliance Hospitals aimed at decreasing ED utilization. CHL meets weekly with members of the change teams in each hospital and with our partner Family Health Connections (FQHC). FHC and Lunenburg, Fitchburg and Heywood Family Practices are NC Primary Care sites with whom we share a majority of patients. Montachusett Opportunity Council (MOC) contracts with CHL to provide care coordination services at their Family Resource Center and consultation to their Head Start

programs. MOC is also a key housing resource in NC. Both the Center for Living Working and the Montachusett Home Care are key resources for our clients in need of long-term support services.

We are active participant in community collaboratives. CHL is the lead agency for Together for Kids Collaborative and the Worcester System of Care. We participate as members in the Domestic Table Round Table, Central Massachusetts Regional Suicide Prevention Coalition, and Promised Neighborhoods. CHL provides leadership in the NC through the Joint Coalition on Health a community health advocacy organization made up of over 30 agencies. Through the CHART projects we are part of the North Central Regional Behavioral Health Collaborative. CHL participates in the CHNA's CHIP initiatives in both the Worcester and North Central areas within their Behavioral Health priorities.

CHL works collaboratively and holds multiple contracts with the Massachusetts Department of Mental Health, Department of Children and Families, Department of Public Health, Department of Early Education and Care, Massachusetts Office of Victim Assistance. We also work closely with the Department of Housing and Community Development, through which we are contracted to provide tenancy preservation services. Our program staff in both the Worcester Service Area and the Gardner-Fitchburg Service Area work regularly with their respective Department of Transitional Assistance offices and U.S. Social Security Administration. We often use Workforce Central in Worcester and the North Central Career Center for employment support.

2. How we will grow connections

Staff from CHL programs continually foster and grow connections within the communities in the Worcester Area and in north central Massachusetts. Active participation in coalition activities expands our network of referrals. Newly hired staff from the communities we serve add their experience and knowledge of resources. Staff attend community events – particularly ones that celebrate diversity and culture – and these add resources to our base of connections. CHL is on the email list of many organizations who weekly compile updates and list of events in the community for distribution – most notably CHNA 9 and JCOH in North Central and the Family Resource Center in Worcester. We expect through the process of this procurement to learn more about the services of the ACOs and MCOs as well as those of other Community Partnerships. In all these ways we will grow the network of community connections to better serve the individuals receiving the CHL's CP service.

3. Plans to ensure staff is informed of community resources

The CHL Community Partner program staff will ensure staff are aware of new community resources through training, supervision and weekly staff meetings. The resource guide is updated regular following staff meetings when new resources or identified or contacts at agencies change. Staff use HelpPro which is an interactive guide to community resources developed by the NC Regional Behavioral Health Collaborative. CHL management is working closely with UMMHC's Integrated Care Department which is working on the development of a resource guide that will help to not only connect Care Coordinators to the community but also increase the community's ability to navigate the health care system. While current staff do use resources on the Web or through 211, they have found that the most effective way to keep informed is through keeping an annotated list of resources.

C. Community Partner supports

1. Outreach and active engagement

a. Outreach and engagement strategies for homeless or hard to reach Assigned Enrollees

Community Healthlink's (CHL's) Community Partner program model is designed to enhance our ability to outreach and to engage Assigned Enrollees. Our Community Partner structure and subcontract with Clinical and Support Options (CSO) has a structure to ensure the right mix and number of staff to fit the work in our catchment areas. Teams are embedded, whenever possible, within primary care and behavioral health sites. Our system will have real-time communication to increase responsiveness and agility. We have designed a workflow to maximize efficiency and avoid duplication. We understand that from the beginning it will be important for the primary care providers (PCP) and of behavioral health providers (BHP) as well as community social service agencies to understand the CP role and responsibilities. During the start-up phase, the CHL CP team will develop materials in a variety of formats – in-person meetings, video, screen savers, handouts, and social media – which describe community partner supports, activities, and collaboration and which can be used with the ACOs or MCOs as well as with Assigned Enrollees and community. The materials for Enrollees will be translated into multiple languages.

CHL's CP program will receive referrals of individuals aged 21 or older; enrolled in an ACO or MCO and who have Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD). Young adults ages 18-20 may be referred if the individual has SUD. Within one business day of Assignment, CHL will confirm the receipt of the Assignment with EOHHS or the MCO or ACO.

After confirming the receipt of the assignment, the CHL Community Partner Intake Coordinator will enter initial information into CHL's Electronic Health Record (EHR) system to start the tracking and data collection for each Assigned Enrollee. We expect that most of individuals referred will have CHL or CSO behavioral health or primary care connections. The Intake Coordinator will check CHL/CSO's behavioral health and primary care EHRs to see what services the individual has received. If there has been recent involvement, the Intake Coordinator will refer the Assigned Enrollee to the CHL Community Partner Team connected to and embedded within his or her[1] PCP or BHP. We will enter CHL Community Partner referral information into CHL's behavioral health record and the Assigned Enrollee will be "flagged" in the EHRs (eClinicalWorks for primary care and NetSmart CMHC/ CareLogic for Behavioral Health) as a Community Partner referral so that all providers are aware. CSO will document the referral in their BH record, Credible, as well.

At intake we will begin to assess any language or access needs the individual may have. We want to make sure from the start that we provide the service in the language and location that best meets the Enrollee's needs. We will have individuals on staff that speak multiple languages and have medical interpreters and video interpreting available as well as telephonic interpreting. We will have telecommunication available for those who are deaf or hard of hearing.

[1] Although we use "his or her" and "he or she" in this response as singular pronouns (the style still endorsed by the APA Publication Manual, the Associated Press Stylebook, and the Chicago Manual of Style), we recognize the need for a new singular pronoun to respect the fact that gender is not binary. At CHL, we support the APA's guidance that providers should, "Respect people's preferences; call people what they prefer to be called." APA Publication Manual, 2010, p. 72.)

We expect to receive an initial number of referrals through EOHHS's Analytical Identification Process. The Intake Coordinator will work closely with the My Link Management Team on this first group of referrals to ensure processes are efficient and meet reporting requirements. The program leadership in addition to the Intake Coordinator, will assist in the review, process, and assignment of these first referrals.

We have organized the CHL CP staff into teams. CHL/CSO will initially have three teams. Each team works with about 270 Enrollees and has a RN, Licensed Clinician, five Care Coordinators and one CHW. As the referrals and caseloads increase, the teams will expand and we will create more teams. We will organize the first CHL Community Partner teams geographically and attach them to (1) CHL's Homeless Outreach and Advocacy Project (HOAP), which is a Federally Qualified Health Center; (2) CHL's Worcester Primary Care and Behavioral Health; and (3) CHL's North Central Primary Care and CSO/CHL Behavioral Health.

All Enrollees will receive a letter and information in the mail introducing the program. Whenever possible, however, Care Coordinators will use existing relationships with providers to make initial connections with the Enrollee. Overwhelmingly, our experience is that "warm-handoffs" make a significant difference in being able to successfully engage individuals in the community. For clients involved with CHL behavioral health or primary care, Care Coordinators will contact the PCP, psychiatrist, clinician, CBFS program, or PACT team working with the individual and set up a time for a teamed contact. Similarly, the assigned Care Coordinator will contact non-CHL/CSO PCPs and behavioral health providers to set up times to meet the Assigned Enrollee at the practice when possible. Staff will arrange to be present for the next appointment and with the client's permission, will make a connection with the client at that visit. The CHL Community Partner program will also be alerted if the Assigned Enrollee comes into one of CHL's Urgent Care or Open Access sites for an unscheduled appointment – either for Primary Care or Behavioral Health. Care Coordinators assigned to those teams will be available to be introduced to Assigned Enrollees, with permission, during these visits.

Our goal will be to have attempt at a face-to-face initial contact with the Assigned Enrollee within the first 30 days. We will use our EHR to track efforts toward that goal. While our preference is to have the first face-to-face Care Coordination encounter occur with a warm-handoff, when this is not successful, our Intake Coordinator will call the Assigned Enrollee or use text messaging to contact the individual to introduce the program and make that first contact. We have found that calls of this nature do not have a high percent of success because clients have caller ID and screen calls, clients have limited minutes on their phones, and because often, contact numbers given to us are incorrect. When individuals are involved in the CHL/CSO systems or have a connection with a community PCP, the Intake Coordinator can coordinate the call with the behavioral health or primary care staff so the call is coming from familiar staff.

As the Emergency Service Provider (ESP) in both North Central and Worcester, we also have the ability for a warm handoff in Emergency Departments. Because the EHR "flag" will be in place, the Emergency Services Communication Center will alert CHL's Community Partner program when they receive a call from an ED regarding a client assigned to the program. Our current care management staff work closely with ED and CHL's Emergency Services in Worcester and North Central. They are comfortable in the settings, have relationships with the ED staff, and are seen

as respected members of the ED teams. We expect that many of our current care managers will move into the role of Care Coordinator or CHW in CHL's Community Partner program.

If the Assigned Enrollee has not had recent contacts with his or her PCP or BHP or is not responding to calls, texts, or the mailing, the team will make an outreach visit. These first visits will be conducted by two CHL Community Partner program staff after a safety assessment and case specific protocol is in place to ensure staff members' safety in the community. The safety assessment includes assessing, for example, the severity of threatening or assaultive behavior and how recent it was, severity of criminal activity in the home or neighborhood, non-adherence with medications or other needed treatment, time of day, and cell phone reception. Each safety assessment is reviewed by a manager and will inform decisions about the visit such as: single or double staff visit; credentials/experience of staff making the visit; time of visit; procedure for checking in with supervisor during or after visit; and developing a plan with the individual or family regarding animals or the presence of other people in the home.

Staff will use the knowledge gained through the years of experience in providing outreach care management and case management to individuals in the Worcester and north central Massachusetts areas to remove the barriers encountered in initial meetings with individuals with complex mental health, substance use, and medical challenges. We have found that homeless individuals who also suffer from mental illness and substance use disorders are often the most difficult to engage and need more extensive outreach. While we will strive to have an initial meeting within our Primary Care settings or with a behavioral health clinician or in Urgent or Emergency care, sometimes we will need to go into the community to find the most at-risk and vulnerable individuals. Our staff are experienced in homeless outreach. We know, for example where individuals in Worcester go for meals: breakfast at St. John's Food for the Poor program or Everyday Miracles, lunch at the Salvation Army, and dinner at the Mustard Seed. The staff know to find homeless individuals at the "triangle" in Fitchburg which is located at the intersection of the train station, Dunkin Donuts and drop-in center. The staff also know the individuals who frequent these locations and the individuals trust them. Homeless individuals know to look for our care management staff to get help. Equally important, our staff know the areas where they should not go. There are wooded areas and tunnels as well as buildings that are known for drug traffic that CHL staff do not enter.

In our experience, a warm-handoff and meeting is the key to successful engagement. It allows us to make a connection is a known setting and often with a provider whom the individual trusts. In these initial meetings, the Care Managers will share information about the CHL Community Partner program and begin to learn about the client and his or her needs. The goal of the visit is to build rapport and engagement. Staff do that by being understanding and empathic; by using body language that shows respect; and by talking with the individual, not "at" them. Staff are trained to be flexible in their approaches depending on the individual. For example, staff find that having a "streetwise" stance and approach works well with some homeless individuals and in other situations, a caring, warm interaction is more successful.

Our staff know the community and in a very first meeting can often provide concrete help or make a needed referral. We often make connections on the first visit to food pantries and to behavioral health providers. These concrete services help the engagement process because we

help the client with something he or she cares about in the very first encounter. In this way, we begin to get an idea of what the client's goals may be even though we most often will not formally complete an assessment or care plan in this first encounter. In all cases, the staff in this and other early visits convey the ideas that "I am willing to help you if you want to engage" and that "you are in charge of your plan."

b. Outreach and engagement strategies for Assigned Enrollees with SUD

In our current Care Management and Community Support Programs (CSP), 67% of the individuals with whom we work have a diagnosed substance use disorder (SUD). CHL provides a continuum of care for individuals with SUD including: Acute Treatment Service (ATS) (Detox), Clinical Stabilization Services (CSS), Transitional Support Services (TSS), Medication Assisted Treatment (MAT), as well as substance abuse outpatient and residential services.

Our Care Management and CSP staff provide follow-up community based interventions with individuals referred from all levels of SUD care. Staff receive extensive training in SUD and in Motivational Interviewing (MI). Staff practice with role playing in team and supervision to learn ways to work most effectively with this population.

CHL uses the SAMHSA guiding principles of recovery as a base for our work with individuals suffering from SUD and mental illness. Our work is person-driven and we understand that recovery occurs via many pathways and is highly individualized. Our staff are trained in providing trauma-informed care as so many of the individuals referred are victims of trauma. The services and supports we provide are trauma-informed to foster safety and trust. Our person-centered plans will reflect our view of recovery as holistic and will address self-care, family, housing, employment, transportation, education, health care, faith supports, social networks, and recreation – which are all aspects of recovery.

The staff use MI effectively in their planning with individuals who are in the pre-contemplation stage of treatment and recovery. If "being there for my kids" is important, for example, then the staff help the individual identify what is getting in the way of the individual's parenting. Similarly, if housing is a goal because the individual is continually being evicted, staff work with the individual to help him or her list what he or she sees as the barriers to housing. The staff "plant seeds" which eventually take hold and become embraced by the client as their own. Staff use motivational interviewing strategies to help individuals move from ambivalence to action.

We currently have a team of community outreach staff that work with individuals being discharged from Detox. The CSP team encounters individuals who have had multiple recent admissions yet continue to state that drugs or alcohol is not a problem for them when they are working on the collaborative care plan. One outreach staff described an individual with three admissions to Detox in four months. While he was still pre-contemplative and would not list decreasing substance use as a goal, he did agree that he was depressed. The outreach worker connected him with a CHL therapist who engaged with him around the depression and over time, the individual acknowledged the impact drugs were having on him, and eventually included that in his care plan. He has now been drug-free for 6 months after having had a few starts and stops.

Many of those with a SUD are also homeless, and we would follow the outreach process described above in 1.a. We keep staff as safe as possible by having them outreach as a team when necessary and not going into areas when drug deals are likely to be happening. Staff always check in and out with a supervisor. We have also found that engagement of this population often takes multiple tries over longer stretches of time and therefore in our staffing pattern we have engagement specialists – Community Health Workers – who will carry smaller caseloads and provide more intense outreach in order to reach this vulnerable population.

c. Obtaining and documenting Assigned Enrollees' agreement to participate

In the first "warm handoff" visit, staff will verify contact information, find the best ways to contact the individual and set up a time and place to work on an assessment. Staff also have business cards which they distribute so that clients have contact information for the Care Coordinators. In this first visit, CHL staff will provide information about the benefits and purpose of the CHL Community Partners program and on the community partner supports available. Included in the brochure each individual will receive is information about choosing to opt-out of the CP Support and about the ability to request to be assigned to a different CP. In addition, the brochure will have information about Client Rights and Privacy.

Based on our experience, we expect that it may take 2-3 attempts to engage – sign a participation form. We will plan with the client a second visit in their home, at a CHL office, or at a community site. At that next visit staff will: (1) Provide additional information about the benefits and purpose of Care Coordination; (2) explain and obtain the signed participation form; (3) explain what Protected Information is and have the Assigned Enrollee give written authorization (ROI) in order to contact current providers and newly identified referrals as necessary; and (4) will begin the Comprehensive Assessment and Person-Centered Plan.

When the participation form is signed, it is returned to the Intake Coordinator to be scanned into the Care Management Record. The form triggers a reminder that we need to assign a Care Coordinator within 5 business days. The form will also trigger a notice to be sent to the Primary Care and Behavioral Health providers showing that the individual is now enrolled in CHL's Community Partner program. It will also list the assigned Care Coordinator and his or her contact information. PatientPing will be updated with the Care Coordinator's name. Whenever possible, we will assign the Care Coordinator (CC) who connects with the client and obtains the participation form as the Care Coordinator for the Enrollee.

We currently participate in PatientPing, a web-based, HIPAA-compliant platform which began in 2016. Five of the seven hospitals in our catchment have or will have PatientPing in place by the end of the year. We will expand our current use of PatientPing through this initiative so that the system will flag all Enrollees as patients of CHL's Community Partner program. This will allow our staff to receive real-time information (through text, with no PHI, and secure email) when an emergency department admits a CHL CP patient. PatientPing's clinical event notification platform sends real-time messages ("pings") to Care Coordinators who are then able to meet Enrollees in the emergency department.

Because we see Engagement (completion of a signed participation form) as key to the on-going work of Care Coordination we have chosen the Engagement process as our first quality Using

the Lean approach and tools, staff and managers will review data together and look at ways that policies, procedures, staffing, case assignments, etc., might be revised to meet the goal of engaging 60% of referred individuals within three calendar months from referral.

2. Comprehensive assessment and person-centered treatment planning
a. Process for conducting comprehensive assessments (CAs)
After the Engaged Enrollee has agreed to participate and releases are in place, the Care Coordinator conducts the Comprehensive Assessment (CA) within three calendar months of assignment to CHL's Community Partner program. The assessment is a collaborative effort. For our CA tool, we are using the Massachusetts Standard Documentation Project (MSDP) forms with a few additions so that it contains all the required domains. It is the Assessment CHL and CSO currently use. This tool is in our current EHR and will be in CareLogic as well.

The Care Coordinator collaborates with the CP team on the assessment and will review information from both Primary Care and BH providers. When appropriate, and when there is a CA that has been completed within the three months prior to the CP assessment that includes all domains, we may choose to use that CA rather than complete a new assessment. In this case, assessment information will be reviewed with the Enrollee during the assessment interview(s).

Staff will set-up times and locations to meet based on the Enrollee's preference and will take into consideration any language or access needs in planning for the assessment. Staff will have tablets or laptops so they have the ability to record information collaboratively with the Enrollee.

Staff will conduct interviews to learn about each individual's biopsychosocial history, presenting problems, current use of available resources and assess the clients' strengths and needs as well as presence of natural supports. The staff will gather data about the Enrollee's medical history, health status and medication. Staff will pay particular attention to social determinants of health in the assessment process. Staff will establish a means of contact between the Enrollee and CHL's Community Partner program. As appropriate, the Care Coordinator will review concerns about identified risk factors and assist the Enrollee in writing a crisis prevention or safety plan. In all interviews, staff will ensure that the individual has information about accessing urgent and emergency behavioral health and medical care.

During the assessment we will also complete an SF-12 with the Assigned Enrollee. The SF-12 is a multipurpose short-form (SF) generic measure of health status. It was developed to be a much shorter, yet valid, alternative to the SF-36 for use in large surveys of general and specific populations as well as large longitudinal studies of health outcomes. The 12 items include one or two items from each of eight health concepts: physical functioning, role limitations due to physical health problems, bodily pain, general health, vitality (energy/fatigue), social functioning, role limitations due to emotional problems and mental health (psychological distress and psychological well being). We will redo the SF-12 at six month intervals and use the outcome data to inform our practice moving forward.

After the CA has been completed by the Care Coordinator and the Enrollee and the medical history, medical needs, and medications are reviewed by the RN on the Care Team, the full CA is then reviewed by the team's clinical manager. The signature of the Clinical Care Manager

signals completion of the Assessment within the EHR. It also gets communicated – electronically when possible - to those involved in the Care Team (with releases from the Enrollee). This assessment will be updated annually. The EHR alerts staff when updates are due.

For individuals that are most vulnerable – homeless individuals, dually-diagnosed individuals, and substance users in a pre-contemplative stage of recovery – the assessment process may not be completed in this face-to-face visit. We expect multiple outreach efforts may be needed with these individuals before the assessment is completed. CHL's Community Partner teams may choose to have their engagement specialists – Community Health Workers (CHW) – work with these individuals and complete the assessment. See Attachment I: Assessment Tool.

b. Process for conducting person-centered treatment plans (PCTP)

1) Processes for developing the PCTP

As part of the Comprehensive Assessment, the Care Coordinator and the Assigned Enrollee will begin the Person-Centered Treatment Planning process. The PCTP will be completed within three calendar months of the Enrollee's Assignment to CHL.

CHL sees person-centered planning as a collaborative process, directed by the client in partnership with the care providers and natural supporters. Because "person-centered planning is a process directed by the participant, intended to identify strengths, capacities, preferences, needs and desired outcomes of the participant" (Centers for Medicare and Medicaid) the plans are, by definition, unique to each individual.

In some cases, we will be able to develop the plan with the Assigned Enrollee, members of the CHL Community Partner team (Care Coordinator, RN, Clinical Care Manager), the PCP (or designee), the behavioral health provider, and natural or family supports. In most cases, the Care Coordinator, the individual and a smaller team will work on the plan. Plans developed by the LPN Care Coordinators will be reviewed and cosigned by the team's RN or Licensed team leader. When the Assigned Enrollee has approved the plan by signing it, the plan it will be sent to the PCP (or designee) for approval if he or she was not in attendance. Plans address the individual's health and social needs and the process asks questions related to integrated care: How does this individual's behavioral health condition affect this medical condition? How does the treatment of medical symptoms affect the individual's behavioral health? How does living on the street affect the individual's health? The need to make adjustments based on the response to these types of questions is why all team members need input.

In all PCTP meetings we use shared decision making, embrace cultural preferences, and encourage individuals to think about their life and health in all aspects. Staff are trained to listen, promote hopefulness, be creative and flexible, and have clear communication. Many CHL staff have been trained and certified by the Transformation Center in person-centered planning. Our staff will also be trained in treatment team facilitation by Tuyet Tran, the Director of Integrated Care Management for CHL and Dr. Anthony Irsfeld who is our CSA Director and a skilled state-wide recognized trainer in person-centered treatment planning.

Plans are purposefully designed around the individual's strengths and abilities with an underlying theme of fostering empowerment, independence, wellness, and improved level of

functioning. Staff encourage clients to identify skills and abilities they already possess that will help them achieve their goals while also specifying how the care team will support these efforts with solution-focused interventions. Listening to understand the Enrollee's culture and the ways it may affect health and wellness is key to a successful plan. As with the assessment, the Care Coordinator will ensure that the Plan process takes place in an accessible location and is conducted in the enrollee's preferred language.

Each plan includes statements by the Assigned Enrollee about goals in his/her own words. The individual also prioritizes what he or she thinks is most important. Our staff are trained in writing SMART goals – Specific, Measurable, Attainable, Realistic, and Time Sensitive. Writing specific objectives (short-term) within each longer-term goal toward health has been effective in helping our clients to see and celebrate even small increments of improvement as well as to help manage complex health conditions.

The plan includes not only the individual's action steps but also identifies what each provider on the team will do to assist the Enrollee in moving toward his or her goal. The types, frequency, and duration of services are listed. Any barriers to meeting the goals are addressed and listed with actions to remedy or mitigate those barriers.

Each plan includes the list of contact information for members of the team including names, telephone numbers, email addresses. A key part of the plan is the description of how the team will coordinate care on an ongoing basis, including determining when the team meetings will be held and how will the members of the team will communicate with one another.

All PCTPs contain emergency contacts and information on how to access both medical and behavioral health urgent and emergency care. Some individuals may have crisis plans developed by the BH provider or by the CC under the supervision of the Licensed Clinician that may include warning signs, coping strategies, and community and natural supports in addition to the contact information for the Care Team. The Enrollee receives a copy of the crisis plan (if necessary) and contact information as part of the Treatment Planning document.

2) Processes for documenting the PCTP

Both our current and new EHR have PCTP formats following the MSDP standards that we will edit to meet the CP requirements. The Care Coordinators will have tablets/laptops with signature pads so the Plans can be completed and signed by the Enrollee during the TP meeting.

The CP staff will then forward the PCTP to the PCP (or designee) for their signature. Our CareLogic vendor is working with both eClinicalWorks and EPIC (UMMHC's record) to connect the EHRs so that documents and some data can be easily exchanged. The completed, PCP signed plan will be mailed or delivered to the Enrollee or available through their portal.

Once the plan has been signed by the Enrollee and by the PCP - the PCTP then becomes a part of the EMR and will be shared with other members of the Enrollee's Care Team, when appropriate releases are in place, including the ACO or MCO, state agencies, and other community providers. It will be sent securely electronically whenever possible. The EHR reminds the team through an alert system that the PCTP is due for update six months after it has been approved.

3) Processes for updating the PCTP
The PCTP is a living document and therefore may be reviewed at any time there is a change in the Engaged Enrollee's status or at least every six months.

The team will gather as possible and will together review and update the plan. At the six-month review and any time the plan is updated, the Care Team will review the individual's health status and progress toward goals, and will assess and add new goals and recommendations based on reassessments. The Care Team will again look at ways to decrease barriers to care if any are identified in the process. Next, the actions are updated to reflect new frequency and duration, and team members are assigned tasks. The contact list and crisis plan is reviewed and updated as needed. The team reviews its communication plan and makes improvements. The updated plan will be approved with signatures from both the Enrollee and the PCP (or designee) and entered into the EHR. Members of the Care Team will receive copies of the up-dated plan.

4) Process for ensuring Enrollee's approval of PCTP
The plan needs approval from the Enrollee and the PCP (or designee). Staff will obtain the Enrollee's signature during the PCTP meeting with a signature pad. Other members of the Care Team may sign the plan if they are present during the planning meeting.

When the Care Coordinator is embedded in the Enrollee's PCP practice we may obtain the approval signature during weekly huddles. We also may obtain the PCP signature through our EHR data exchange and the PCP (or designee) will receive an EHR alert that a Care Plan is awaiting signature. In some cases, we will fax or email (secure) the Plan to the PCP site for the signature. The program administrative assistant will follow-up if there are delays.

CHL and CSO sees this process as a challenge given the fast pace of PCP practices. We will work closely with the PCPs to have this process be efficient as well as informative. We believe that providing early and regular information about Community Partners, having clear role definition, and communicating regularly in-person will be key to this approval process.

3. Care coordination and care management
a. Identifying stakeholders
During the engagement process and through the assessment, the Care Coordinator and the CHL Community Partner program team will work with the Engaged Enrollee to identify the members of his or her Care Team. The Care Coordinator will meet with the Enrollee and make a list of those individuals the Enrollee identifies. In our experience, individuals are more likely to easily identify professionals: doctors, therapists, case managers, etc. Our staff will encourage the Enrollee to think beyond the professionals and add to their team when possible natural supports - family members or other caregivers, friends, or community supports.

From the initial meeting when we talk about the program we will begin talking about the Care Team and our expectation that the Care Coordinator and the Clinical Care Manager will be standard Care Team members and that in addition, the Enrollee's PCP or Designee and Behavioral Health Clinician will be part of the team. When an Enrollee is involved with other community supports such as CBFS or PACT the Enrollee will be encouraged to consider inviting

support members of those teams to participate. Enrollee's receiving case management or other services from a State Agency may choose to include those supports as well. In addition, if he or she is involved with another community agency such as a Clubhouse, peer recovery program, or CSA, staff from those supports can be invited by the Enrollee. CHL's Community Partner program staff will also encourage Enrollees to add natural supports to their team.

Many of the Enrollees will present with complex needs, including trauma histories, poverty, homelessness, and domestic or community violence. By using Care Teams that include community and professional expertise, Care Coordinators do not have to be the experts in all cultures or problems or conditions. For example, a CHL client who is an African refugee invited members of their mosque to participate in the team in order to help the staff understand some of the challenges he faced.

Once the team is identified by the Enrollee, the Care Coordinator will ensure that each member of the team receives information about the role of the CP and Care Coordinator, about the PCTP process, and about the expectations of the Care Team members. We will include information for each identified member about his or her role based on their licensure, training, and relationship to the Enrollee. We will also convey our philosophy that Care Teams should reflect: 1) cultural and linguistic competence; (2) individuals and family, and community involvement at all levels of service delivery; and (3) a strong belief in the importance of positive expectations. The latter cannot be overestimated. For change to occur in complicated situations there must be a sense of hope and a belief that things can get better. For this to occur, Enrollees have to feel understood by, comfortable with, and trusting of professional staff. They must have a sense of their own empowerment – that they by their actions can make a difference.

CHL and CSO have extensive knowledge about gathering and working with Care Teams through our four Community Service Agencies, Care Teams for our high ED users in the CHART programs, and through our team experience with our current managed care contracts with Medicaid and Medicare. In our experience, we also know that Care Teams change and evolve over time based on the Enrollee's needs and preferences. Enrollees, for example, may need a long-term supportive services (LTSS) which would mean bringing information about LTSS providers to the meeting and eventually involve an LTSS provider as part of the care planning.

b. Exchanging information with stakeholders

We see the Care Coordinator as the **hub for communication** between stakeholders. Regular communication with each member of the Enrollee's Care Team is a primary responsibility of the team. It is also a challenge because all members of Care Teams have high caseloads and demands. Our goal is to have the information exchange be a value-add for all the members of the team so that we can count on their participation in the Enrollee's plan. Communication across disciplines, geography, and electronic records is complicated and we expect to continually review and improve our information exchange process through our QI processes.

We do have some immediate capacity for information exchange through the electronic record. CHL's Community Partner program staff will have access to the Primary Care Record of CHL clients and to the CHL Behavioral Health record. These two records will have linkages so that there is real time communication between the two record systems. Both systems have "tasking"

and "messaging" functions. Both systems will have CHL's Community Partner program Enrollees flagged so that Care Coordinators can be notified both when a patient is scheduled to come to an appointment and when a patient arrives. PCPs and BH clinicians will be able to read contact notes and Care Plan updates from the Care Coordinators in the EHR. We have capability of sending information from our electronic record to other entities through the MassHIway and Continuing Care Documents.

Our embedded model lends itself to face-to-face communication. Care Coordinators will participate in daily or weekly team meetings or "huddles" with the PCP and BH staff. The huddles which we currently have in place for CHL's OneCare Case Management have proven to be an efficient way to regularly communicate. Multidisciplinary staff are present and it is an opportunity to talk about challenges, risks, wellness opportunities, upcoming appointments and to review progress toward goals.

For community agencies, state agencies, and natural supports, we will also exchange information and updates thorough regular telephone contacts, secure email, and by fax. In all situations, we will ensure that we have in place appropriate and valid ROIs.

c. Identifying and organizing Enrollee's care team

CHL's care management is flexible and mobile. Its primary aim is to help individuals with complex needs better manage their health and wellbeing by coordinating care with PCPs and BH clinicians and addressing barriers to health care. This includes challenges related to social issues such as housing, benefits, transportation and food insecurity. We find that working closely with the multidisciplinary Care Team – even without physically meeting – enhances the care.

Care Coordinators meet with Enrollees in homes, shelters, community doctors' offices or speak by phone. They communicate with doctors and help coordinate the agreed upon plan. They participate in interdisciplinary care meetings and daily or weekly huddles. Staff in the home and community are aware of the physical behavioral social and environmental conditions in the Enrollee's personal life and living environment that may affect their health and welfare and safety. Staff can help to articulate in the Enrollee's voice their preferences and strengths. Therefore, they are in a key position to organize and coordinate the Care Team.

When there are Care Team meetings – in person or virtually – the Coordinator will:

- Define roles: With multiple agencies and providers involved with service planning, it can be difficult to know who should be doing what. To avoid confusion and conflict roles of all key providers and stakeholders need to be defined from the onset of the program.
- Enrollee participation: Person-Centered Planning is not simply about inviting an Enrollee to a meeting. Too often they can feel intimidated or unappreciated. The Care Coordinator will support the individual and ensure that their point of view is respected, valued, and heard.
- Meeting preparation: All participants – providers and family members, formal and informal community partners – must understand the purpose of the meeting, its goals and objectives, the process by which decisions are made, and the importance of everyone expressing her/his opinions, perspectives and suggestions.

- Record Attendance and Decisions: The Care Coordinator will list contact information for those in attendance. All members of the team including the Enrollee will receive a copy of this sheet and it will become a part of the electronic record.

When it is not necessary or possible for the team to meet or members of the team are missing from a meeting, the Care Coordinator ensures that all members receive updates regarding the care of the Enrollee. Team members will all have contact information and understand Care Team roles and relationships. As the hub, the Care Coordinator can make certain that an update from DMH, for example, is communicated by phone, email or electronic exchange of information to all members of the team. All these encounters and communication exchange are logged into CHL's BH EHR and are reportable.

d. Ensuring effective ongoing communication

We see Care Coordination as a dynamic process rather than a defined set of tasks -- it involves need identification, assessment, prioritizing, and monitoring of outcomes. The Care Coordinator's primary job after engagement is to communicate, network, educate, and advocate.

A core competency of both CHL's Community Partner program itself and of the individual members of the Community Partner team is the establishment of relationships with outside entities and the development of clear expectations on both sides – particularly around communication. During the development phase and during the first year, we will develop "standard work" around communication with and between Care Team members. We will base decisions on feedback from stakeholders and Enrollees. Results will be shared with our CAB and we will seek their recommendations for improvement.

CSO and CHL will use data from our Care Coordination experience to improve our practice overtime. We are looking at tools that identify risk factors, running reports that target high users and looking at ways to separate high but non-preventable costs from those that are more preventable. CHL's current care management programs follow the principals set forth in the CareOregon model which has been identified by CMS (information bulletin 7/24/13) as a successful model for "super-users". They have created a "community of practice" environment linking the Care Managers to the PCPs and BH providers through: 1) weekly multidisciplinary huddles to discuss challenging cases; 2) standardized tools, workflows, and documentation guidelines; 3) competency-based trainings; and 4) centralized supervision and performance monitoring. In addition, CareOregon uses dashboard reports which contain information on utilization, engagement, caseload capacity, turnover, as well as performance on quality metrics. We will use dashboards with our new EHR. This data will be shared with our primary Stakeholders - along with Enrollee specific information - so that our "community of practice" evolves through data and experience.

4. Care transitions

While the Enrollees receive varying levels of care coordination over time - care coordinators will always prioritize oversight and monitoring of transitions across care settings and from one level of care to another. Transitions, particularly from inpatient stays, are critical times for Care Coordinators to be actively involved with the Enrollee to ensure success in the community.

Our team has relationships with all the local inpatient medical hospitals, ATS programs, substance use continuum programs, and CBFS and PACT programs. In addition, through our ESP, CSP, and CHART programs, we have relationships with staff and units at most inpatient psychiatric facilities throughout the state. Through PatientPing we will be notified when our patients go to an ED or are hospitalized.

The Enrollee's Care Coordinator or another member of their CHL's CP Team will attend treatment team and discharge meetings at the hospital whenever possible (and by phone call if necessary) and be responsible to inform the other members of the Engaged Enrollee's Care Team – the PCP, behavioral health providers, ACO/MCO and others - about the discharge plan. Current staff have countless examples of the importance of attending discharge meetings. Inpatient units are frequently not familiar enough with the community to make effective referrals e.g. they are often not aware of barriers such as transportation or challenges with in-home referrals. Therefore, inpatient units want to consult with staff about possible plans.

While Care Coordinators will have been in contact with the inpatient hospital and will have been part of the discharge planning process, follow-up in the community is key. When possible, after an inpatient stay, the RN and Care Coordinator will visit the Enrollee **together** in order to complete the Medication Reconciliation and review the PCTP . They will update and then distribute the Treatment Plan following the process in 2.b.3) above.

CHL's Care Coordinators will work with clients who have been recently discharged to make direct face-to-face warm handoffs of care when that is appropriate and necessary. They will bring clients to the Partial Hospitalization programs, introduce them to staff at the Clubhouses, take clients to first appointments when necessary and then arrange for transportation for follow-up appointments. Making these "warm handoffs" increases the success in the community.
In all cases the Enrollee's Care Team will be informed about the discharge meeting, transition visit in the community, and the updated Plan. With permission, the Care Coordinator arranges for the sharing of information between the Care Team and any new providers.

5. Medication reconciliation
Within three days of discharge from an inpatient unit, Engaged Enrollees' CHL Community Partner program team will conduct a face-to -face visit. Whenever possible the RN or LPN will attend with the Care Coordinator so that as a team with the Enrollee, they update Enrollee's treatment plan and discuss the coordination of additional support services. The RN or LPN will review discharge orders and contact the Enrollee's PCP to verify that the orders are appropriate. In the visit, the nurse will ensure that the medication orders have been filled accurately. In addition, the nurse will review each medication with the Enrollee and make certain the individual understands the medication regimen and is knowledgeable about side effects and has his or her questions answered. If applicable, the nurse, with the Care Coordinator, will assist the individual in contacting staff or natural supports that may support the individual. When the Engaged Enrollee is an individual in a Medication Assistance Program (MAP), the RN or LPN will share the updated order forms with the MAP provider and make certain there is communication regarding any changes.

Within our CHL Community Partner program team structure, we will have staff that work closely with the CBFS program specifically. Whenever possible it will be that RN or LPN and Care Coordinator that responds within the three days of discharge. The team will be organized in such a way that the discharge visits can occur in a timely fashion on long weekends and holidays. In addition, the Care Coordinator will follow-up with the Enrollee after the visit to make sure that any additional questions or concerns are addressed. The RN will consult as needed.

6. Health and wellness coaching

a. Plans for conducting health and wellness education and coaching

Research indicates that the average life span of individuals with severe mental illness is 10 to 20 years shorter than that of the general population (National Council for Behavioral Health). Factors contributing to this are complex and include; greater risk for diabetes, hypertension and cardiovascular disease often due to weight gain that results from poor nutrition and adverse side effects of medication; individuals with mental illness are frequently forced into poverty; become addicted to tobacco alcohol and other drugs, etc.

Recognizing this, in 2015, CHL and CSO began agency-wide wellness and integrated care initiatives beginning with a series of two-day trainings provided by the National Council for Behavioral Health. Through a "train the trainer" program eventually all staff were trained in material by the National Council. As a result of this initiative, CHL clients have a wellness goal in their plans which is tracked and measured. It is one way we are integrating health and wellness into our day to day behavioral health and primary care practice.

Care Coordinators will work with each Enrolled Enrollee to match them with a wellness goal that works for them. For some, it will be to participate in CHL's PCP Wellness coaching or Wellness classes. For others it will be to take advantages of our YMCA memberships or of local recreation programs. CBFS has gym and hiking groups which are highly successful. CHL Community Partner program staff will be knowledgeable about wellness opportunities in the community many of which are free, for example: nutrition consultation at the Tuesday Farmer Market; Stress Reduction seminars at PCP practices; and local recreation programs. Staff will also be aware of any wellness programs within the ACO/MCO that members my take advantage of such as weight management services or access to fitness programs and nutrition counseling. There are also self-health guides and resources available through UMMHC's website and Wellness Resource Library which staff will use with Enrollees.

CHL Community Partner program staff will help make connections - including attending a first class with a reluctant client - in order to ensure that each client is matched with a wellness goal that is both attainable and a stretch for them.

One of our wellness programs is In SHAPE, (Individualized Self Health Action Plan for Empowerment) which was developed by Monadnock Family Services and Dartmouth University. It is proving to be highly successful in our integrated primary care clinic in Leominster. Clients are assigned with a mentor who is an individual cheer leader and coach. Care Coordinators will assist clients who participate in the InSHAPE program. In addition, staff will be trained in MyPlate (USDA nutrition best practice) and QuitWorks (which is the MA smoking quit line that our Enrollees can be referred to for smoking cessation and which offers

free patches and counseling). We expect that a variety of EBP modules using smart phone apps will be developed over the upcoming year. Currently we use "Craving to Quit" which is a smart phone app developed by Judson Brewer MD at UMass Medical School's Center for Mindfulness.

Our CSA nurse consultant developed a series of wellness trainings for staff and materials in a readable format on each topic that the staff use with families. We have found this to be effective and will follow this model with the CHL' CP program.

b. Methods for tracking Enrollee's health and wellness goals

Health and Wellness goals are a component of all Treatment Plans at CHL and will be for individuals in CHL Community Partner program. Staff will work with the Enrollee and the Care Team to identify a measurable wellness goal(s). The goals will be listed in SMART format on the Treatment Plan and tracked through the treatment plan reviews. The PCPs will be aware of the wellness goals through the Treatment Plan approval process. During regular weekly huddles with PCPs the goals and progress can be discussed and plans modified as needed.

7. Connection to community and social services

CSO and CHL's strength is in effectively connecting individuals to community and social services. Staff are recruited from the communities, they are orientated and updated around resources, they make personnel connections within the provider communities, they have experiences which they report back to the team and then use that information to assist in future connections. The team has a regularly reviewed an updated service directory. They use online resources including HelpPro in north central Massachusetts and 211 in other areas to assist in finding unique new resources. Staff receive emails from various coalitions which list upcoming events and new services. Weekly team meetings include an agenda item to share any new resources or connections. Pre-service training includes going to community agencies with seasoned staff and learning about the service and meeting individuals at the agency.

When staff are asked what is the most important about making an effective referral, they would include three items. First, the Enrollee needs to be in agreement with the plan. Second, there needs to be a good match between the Enrollee's identified need and the resource and third, there needs to be a warm handoff. Staff attending the first appointment at a behavioral health clinic or at primary care or at a Salvation Army lunch, or a meeting at Work Force Central is key to success. A simple phone call and referral is rarely enough, in our experience.

For the CHL CP program, the collaborative PCTP will be the guide to the community connections that the staff will network with on behalf of the Engaged Enrollees. Individuals will identify for their Care Coordinator and care team which goals are most important for them. Staff will try to ensure that food, housing, safety and access to benefits are met first if they are on the list of Enrollee needs.

Through our current work with Medicaid, skilled nursing, and with the CHART programs, staff are developing skills in working with high and super users to decrease ED visits and prevent inpatient hospitalizations. While it has been more difficult to reduce the reliance on paid support – particularly VNA services - our trend line with OneCare patients is slowly dropping in that measurement as well. We believe that the key drivers of success to preventing the risk of

readmission will be the receipt of timely notification of admission to hospitals, using standardized tools to determine the Member's risk and level of need, the ability to leverage technology to improve communication, a strong discharge and transition plan, warm handoffs to community services and post-acute care medication reconciliation.

D. Innovative technologies for service delivery

Community Healthlink (CHL) currently uses several forms of adaptive technologies including apps, devices, software and three key medical records systems including **1) Netsmart CMHC-MIS** paired with "Order Connect" for e-Prescribing for Behavioral Health related care 2) **Advanced Data Systems** (DocAssist/Premier) for Inpatient substance abuse programs and 3) **eCW** for primary care clinics. CHL has enhanced wireless connectivity throughout several locations to enhance the use of eCW including e-Prescribing on iPads and smartphones. All providers at our FQHC are currently using eCW on iPads. Dictation software is widely used and is supported by our EHR's. Several devices used at our primary care practices like EKG and vital sign monitors are inter-faceable with eCW. eCW has the capability of using robo-calls for appointment reminders as well as text messaging in different languages. The use of Robo-calls will be widely expanded for appointment reminders/reminders once our new Qualifacts EHR is implemented. CHL is currently devoting a considerable effort to implementing several aspects of Advancing Care Information, (ACI) to satisfy MACRA requirements by working with the UMass ACO.

Electronic signature pads are used in several CHL sites (inpatient and clinic sites) which cuts down on the use of paper. This will expand even more with the implementation of the new Qualifacts HER. Paired with hotspot connectivity and built-in data plans, CHL will extend the use of mobile devices (e.g., iPads, tablets, SurfacePro, Bluetooth keyboards and portable printer) to community based and in-home programs such as CHL's CP..

Recently, CHL has submitted a request to UMass Memorial Healthcare to purchase automatic pill counters for some programs through and a Pyxis for our substance abuse continuum (3 inpatient programs) through UMMHC innovation fund. Additionally, CHL is currently working on making remote conferencing available to its managers by implementing join.me and WebEx.

Among the innovative security applications that CHL has in scope for implementation, we have launched a mobile device management application called Maas360. The application secures all texting, corporate emails, web-browsing and all forms of corporate communication via mobile devices. CHL has full control over erasing all confidential from mobile devices that use Maas360 once lost or stolen.

CHL has experience using care management software through our OneCare Program (eClinical Works) and through our CHART program with HealthAlliance Hospital (NetSmart).

CHL works with Omnicare pharmacy. We currently use handheld scanners to refill prescriptions for high volume programs. This ensures the highest level of accuracy and ensure faster delivery of medication. Staff utilize Mindfulness, Meditation, Carving to Quit (tobacco cessation) and other patient education apps with clients. Qualifacts will have educational materials available in the Enrollee's portal access. We are working closely with UMMHC to increase our use of Telepsychiatry. We are also piloting the use of video interpreting using iPads.

E. Personnel and staffing

1. Organizational chart

Please see the CP Organizational Chart, which reflects the **proposed staffing plan for June 1, 2018**. CHL's Director of Integrated Care Management, Tuyet Tran, LICSW, is the senior leader who will oversee the program. She reports to CHL VP Carolyn Droser, LICSW. As her resume indicates, Ms. Tran has years of experience not only managing CSP, MyLink and OneCare programs but also in program start-up. Dr. Marie Hobart, CHL's Chief Medical Officer, will serve as the Medical Director. The other staff and management positions on the organizational chart and described below will be filled between January 1, 2017 and May 1, 2018.

The CP's Program Director will be a licensed clinician and have responsibility to supervise the team leaders (also licensed clinicians). RNs and LPNs will be supervised by the team leaders on day-to-day operations. They will initially be supervised on nursing functions by CHL Director of Nursing, Audrey Hunter. In January 2019 we will hire an RN as an Assistant Director who will work closely with the Program Director on all aspects of the CP and will supervise nursing staff. We will begin in 2018 with program support provided by two FTEs, an administrative assistant and Intake Coordinator. We will expand by two additional administrative positions in 2020.

CHL's CP will have the support of all CHL's administrative departments; IT, HR, Finance, Billing, Quality Management, Data Analysis, Development and Communication and Facilities to meet the requirements of the contract.

2. Sample staffing model

CHL has designed a multidisciplinary team model to meet the scope of the CP supports. Each team will be led by a licensed clinician. Each team is staffed by an RN and six Care Coordinators one of which is an LPN. One of the Care Coordinators will be designated as a Community Health Worker. The CHW will work with individuals with complex health and social needs who are not engaged in services. Each team of eight is organized to work with approximately 270 clients.

The teams will be assigned where possible to specific PC and BH practices. For example, in Worcester we expect to assign a team(s) to our Homeless Outreach Primary Care FQHC and another team(s) to our OP BH clinic where we serve hundreds of Worcester area CBFS clients about 30% of which currently have a MassHealth product for insurance.

We will begin in June 2018 with three teams and the capacity to serve 810 Enrollees. We plan to hire another two full teams to begin January, 2019 bringing our capacity to 1350 by February, 2019. More teams will begin in May, 2019 and by June our capacity expands to approximately 2360. An 8th team will be hired in January 2020 and our capacity will be 2680.

We expect that by January 2020, CSO will have a full team in the Gardner area and be serving 270 clients. We will have teams working out of the Leominster-Fitchburg area serving 680 clients. The remaining five teams we expect to have in the Worcester area. The teams can move between sites as the demand requires and smaller teams may be necessary. For example, we will start the CSO Gardner team with a part-time licensed clinician and RN and two Care Coordinators and grow that team over the next year as we receive referrals.

3. Recruitment plans

CHL will be aggressive in recruiting for the new positions in the CP program and follow successful strategies that have been deployed in previous start-up efforts. CHL will use electronic job boards, email list and announcements sent through our coalition connections.

We currently have recruitment staff attend job fairs at colleges and heath related facilities which we will continue with a focus on this program. CHL also holds Job Fairs annually and have had great success – recently as a result of a 2 hour afternoon Job Fair we hired 5 BA level staff.

Another component of the strategy is to recruit from local colleges and universities including Assumption College, Clark University, Worcester State University, Quinsigamond Community College, Mount Wachusett and Fitchburg State to identify qualified and interested candidates. This program offers an additional attraction to mental health professionals interested in working in an integrated care model. CHL managers and human resource staff will emphasize this feature in published recruiting efforts for the program.

We have current experienced employees interested in the Integrated Care model whom we may recruit for the Care Coordinator and clinical supervisory positions. In addition, we will work closely with the Center for Health Impact to hire graduates from their Community Health Worker classes.

All of these strategies will be used during the recruitment process with a goal that all employees are hired within the following timeframes. Once staff is hired, their pre- service training will begin. Below is a hiring plan.

Task	**Timeframe**
Post all positions within CHL, Monster Board, CHL website, identified colleges and universities	Initial Notification from EOHHS (November 2017)
Networking by CHL managers with potential recruits/ Application and resumes screened by HR/ Interviews of candidates	November 2017- May 2018
Hire CP Program Manager	March 2018
Hire 3 RNs, 3 Clinical Care Managers, Administrative Assistant, and Intake Coordinator	April 2018
Hire 18 Care Coordinators (includes CSO staff)	May 2018
Second Round of Hiring- Post all positions within CHL, Monster Board, CHL website, identified colleges and universities	October 2018
Networking by CHL managers with potential recruits/ Application and resumes screened by HR/Interviews of candidates	November -December 2018
Two more full teams of Clinical Care Managers, RNs and Care Coordinators begin training	January 2019
Recruitment of two additional administrative staff and the RN Assistant Director	January 2019
Networking by CHL managers with potential recruits/ Application and resumes screened by HR/Interviews of candidates	February 2019
Assistant Director, RN and Administrative staff begin training	March 2019

Third Round of Hiring- Post all positions within CHL, Monster Board, CHL website, identified colleges and universities	March 2019
Networking by CHL managers with potential recruits/ Application and resumes screened by HR/Interviews of candidates	April 2019
Two more full teams of Clinical Care Managers, RNs and Care Coordinators begin training	May 2019
Fourth Round of Hiring- Post all positions within CHL, Monster Board, CHL website, identified colleges and universities	November 2019
Networking by CHL managers with potential recruits/ Application and resumes screened by HR/Interviews of candidates	December 2019
One team of Clinical Care Managers, RNs and Care Coordinators begin training	January 2020

4. Recruiting and hiring diverse staff

CHL strives to maintain a diverse workforce that mirrors the diversity of our clients and community. In July 2014, in response to one of CHL's strategic initiatives, we established a CLAS Task Force including staff from all departments and levels and representing the diversity of the organization. The currently employed staff who would serve as the Program Director of the CP Program is an active member of this Task Force. The Task Force as two of its goals to (1) Recruit and retain a culturally diverse workforce at all levels of the organization that is reflective of the populations we serve and (2) Maintain accurate demographic data to monitor and evaluate the impact of CLAS-related activities. We monitor the demographic data of our community, of our clients and of our staff. We have been successful across the agency in recruiting from the cultural and linguistic communities we serve. For example, of the 24 staff including supervisors in our MyLink and CCA OneCare programs 33% are White; 17% are African American; 17% Africans (from Ghana); 20% Latino/a/s and 13% are Vietnamese. This diversity reflects the community in which we work and allows clients to receive services in both their own culture and language.

As a result of the identified diversity and our CLAS TaskForce strategies, CHL, when hiring our program staff, will strategically seek to hire individuals from diverse communities who are bilingual in the top languages spoken by our clients. Staff who speak a language in addition to English receive additional compensation We post the job positions with linguistic or culturally-based affinity groups for individuals in those professions, including (but not limited to):

- The Latino Social Workers Organization (http://www.lswo.org/)
- The National Association of Puerto Rican Hispanic Social Workers (http://www.naprhsw.org)
- The National Association of Black Social Workers (http://nabsw.org/)
- The Asian and Pacific Islander Social Work Educators Association (http://www.apisocialwork.org/)

We will also work closely with the Center for Health Impact which trains individuals from Central MA's diverse communities for medical translation and Community Health Work.

5. Proposed training and orientation plans

We have set-up our hiring plan and budget and use of DSRIP funds so that every multidisciplinary in CP will receive a full month of training in advance of working with clients in the community. We are hiring and creating teams in order to build trust, promote collaboration and thus enhancing care as team members tend to connect overtime. A cohesive team creates shared responsibility and support. We believe that this will help in retention. The initial training outline includes orientation to the agency, the population CP will serve, the community resources, skill development, documentation and safety. All staff will receive the basic orientation and each discipline will receive specialized training. RN's for example will receive training from CHL's nursing director on nursing policies and procedures including documentation and medication reconciliation. The supervisors will receive training from HR on CHL supervision and management protocols.

Our plan is to use Center for Health Impact trainers for 40 hours of training. Since 2005 they have provided a career focused college supported educational pipeline for CHWs and supervisors. Their program is based on standards from the National Community Health Advisory Study titled "Weaving the Future". We have partnered with CHI because of their history of work in this field and our previous collaborations. Their mission statement, "To enhance access to quality health care, eliminate health disparities, and promote workforce development", is an excellent match to our CP program and vision. CHI will train all staff in the core competencies of Community Health. Their training will be tailored to the discipline. Nurses will and supervisors will receive CHI's supervision and nursing modules, for example. We will utilize their Care Transitions Education Project (CTEP) curriculum (initially developed for nurses), for example, in skill development around care transitions. CHI has curriculum in specialized health areas including the opioid crisis. The training listed below is an outline of our training plan.

We know that we will have staff leaving positions and that we will have vacancies to fill when we are not training a whole cohort. At those times, we will, when possible, link new staff to CHI trainings at the CHI site; supervisors and the Program Manager will provide training; and we plan to have all the training available online and through videos so that the training program is sustainable overtime. Information about CHI and the outline of their curriculum and CHW toolkit funded through the Health Care Work force Transformation fund is available on the CHI website for review.

Agency Orientation CHL programs Quality Management/Lean training Compliance	Infection Control Privacy and HIPPA regulations Reporting Abuse/neglect
Program Orientation Introduction to Community Partnerships Program vision	Health Care reform Roles of team members Team Building activities
Population: Serious Mental Illness Substance Use Disorders	Chronic Medical Conditions Service Continuum
Social Determinants of Health Understanding interface between poverty, mental illness, substance use and health	National Council on Behavioral Health training on Integrated Care Models Community Resources: food, housing, benefits
Introduction to Chronic Medical Conditions and Medications/side effects	Asthma Obesity

Diabetes COPD Metabolic syndrome	Tobacco cessation resources Overview of common medical and psychiatric medications and side effects
Community Introduction to social service system	Review of resource guides Meeting key community resources
Skill Development Motivational Interviewing Writing Assessments	Person-Centered Treatment Planning Wraparound model Transitions of Care Safety Planning
Safety Know your community Safety policies and procedures	De-escalation training CHL Violence Prevention Protocals
Documentation Orientation to Electronic record Logging of activities	Writing assessments/plans Writing activity notes
Boundaries	
Self Care and use of Supervision	

6. Staff retention strategy

CHL's staff retention efforts are multi-faceted in nature. Our overall approach is an increased focus on employee diversity, inclusion, and engagement. If staff feel more included and respected in their work environments, then they are more likely to be engaged and less likely to leave the organization. Approximately, three years ago, CHL developed an Inclusion Initiative that involves 30 diverse staff members across the organization from various programs, levels, and backgrounds. Over time, the group, cohesively and in smaller sub-committees has identified, emphasized, and addressed the important topic of "taking care of the people, who take care of the people." These committees have taken two of our most recent staff engagement survey data and developed plans to create a work environment that is more welcoming and inclusive. The team developed, for example a Holiday Tool Kit to ensure that holiday celebration activities are inclusive and respectful for all. They have begun a Mentoring Program which offers staff the opportunity to be paired with a manager and learn skills that will help the staff grow professionally. The Inclusion initiative has also developed Team Building Resources for program managers to encourage connections within and across programs and have fun while doing it. Finally we are in the process of training all our managers in the Diversity and Inclusion training developed by our consultants.

In addition, CHL provides salary increases, CEU and certification opportunities and excellent supervision. CHL is a large agency with opportunities for individuals to advance and grow professionally. Our Quality Management Department has trained all staff in Lean thinking and every program has weekly huddles in which line staff share ideas about how to improve (1) client care (2) the support staff receive in their jobs and (3) the financial health of the program.

F. Implementation plan and timeline

Please see Attachment L: Implementation Plan and Timelines.

G. Budget report and budget narrative

Please see:

- Attachment M: Program Budget Report;
- Attachment N: Program Budget Narratives;
- Attachment O: Infrastructure Budget Report; and
- Attachment P: Infrastructure Budget Narrative.

H. Sustainability

Although the future of health care payments is uncertain, we plan to work towards making this model sustainable by focusing on two goals: 1) increasing our value-based payment contracts across CHL and 2) strengthening our ability to evaluate our care through analytic means.

CHL has been a pioneer in receiving value-based contracts in our behavioral health work, particularly through our OneCare contract and our Primary Care Payment Reform (PCPR) project. Through these and other value-based payment programs, we have learned how vital it is to be able to access quality data about our services.

To that end, we are investing significantly in upgrading our infrastructure to be able to keep up with these data-driven programs. Our new EHR, CareLogic, is part of that investment. Additionally, we continue to add data analyst staff positions to the organization. The money being used to fund infrastructure payments are time-limited, finite costs that won't continue beyond the pilot project (IT infrastructure, startup staffing costs that will be taken over by the PMPM payments). We expect to be able to financially support the ongoing costs to maintain this infrastructure.

Additional value-based payment contracts, combined with a more agile data management system and our organization's commitment to continuous quality improvement, makes us hopeful that we will be well-positioned to sustain this program after the initial 5-year time period is over.

I. Quality management and performance monitoring

1. Quality improvement program

CHL is committed to the ongoing improvement of the quality of care its clients receive, as evidenced by the outcomes of that care. We continuously strive to ensure that:

- The treatment we provide incorporates evidence based, effective practices;
- Treatment and services are appropriate for each client's needs, and available when needed;
- We minimize risk to clients, providers, and other, and we prevent errors in the delivery of services;
- Clients' individual needs and expectations are respected; clients – or those whom they designate – have the opportunity to participate in decisions regarding their treatment; and we provide services with sensitivity and caring;
- We provide procedures, treatments, and services in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and all providers of care.

Quality Improvement Principles. Quality improvement is a systematic approach to assessing services and processes and improving them on a priority basis. CHL's approach to quality improvement is based on the following principles:

- ***Customer Focus***. Quality driven organization CHL focuses on our internal and external customers and on meeting or exceeding their needs and expectations.
- **Recovery-oriented**. Services are characterized by a commitment to promoting and preserving wellness and to expanding choice. This approach promotes maximum flexibility and choice to meet individually defined goals and to permit person-centered services.
- **Employee Empowerment**. Effective programs involve people at all levels of the organization in improving quality. Everyone one at CHL should see their function as to not only do the work but improve the work.
- **Leadership Involvement**. Strong leadership, direction and support of quality improvement activities by the governing body and CEO are key to performance improvement. This involvement of organizational leadership assures that quality improvement initiatives are consistent with provider mission and/or strategic plan.
- **Data-Informed Practice**. Successful QI processes create feedback loops, using data to inform practice and measure results. Fact-based decisions are likely to be correct decisions.
- **Statistical Tools**. For continuous improvement of care, tools and methods are needed that foster knowledge and understanding. CQI organizations use a defined set of analytic tools such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts to turn data into information.
- **Prevention Over Correction**. Continuous Quality Improvement entities seek to design good processes to achieve excellent outcomes rather than fix processes after the fact.
- **Continuous Improvement**. Processes must be continually reviewed and improved. Small incremental changes do make an impact, and providers can almost always find an opportunity to make things better.

Continuous Quality Improvement Activities. Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by CHL leadership, is understood, accepted and used throughout the organization. Staff at all levels of the organization are involved in continuous improvement activities. Training and systems that

support improvement activities enable staff to more fully participate in ongoing improvement efforts. Quality Improvement at CHL involves these primary activities:

- Alignment of quality improvement efforts with CHL's True North Metrics (CHL's strategic goals and metrics)
- Engagement of all staff in continuous quality improvement through access to idea systems and training in LEAN thinking, methodology and tools.
- Measuring and assessing the performance of clinical and support services through the collection and analysis of data.
- Conducting quality improvement initiatives including the design of new services, and/or improvement of existing services.

Problem solving using an A-3 approach (a LEAN process/ tool that is based on a deep understanding of the problem) to address larger problems and the use of idea systems and PDSA cycles to address smaller problems

2. Proposed quality initiative

Care coordination and management starts with the engagement of the assigned enrollee. Our experience has shown us that many mitigating factors such as homelessness, chronic substance use disorders, ongoing mental health challenges, etc. significantly increase the complexity of the outreach necessary to effectively maximize an enrollee's participation in services. Our first quality initiative will be to determine the most effective outreach strategies that will result in enrollee engagement.

Objectives within this goal are: outreach to all assigned enrollees within 30 days of assignment and at least one face-to- face contact within 3 months of assignment.

We will use contract specifications to define measures for success. Engagement is defined as obtaining a signed participation form from the enrollee and the assignment of a care coordinator.

Our initial goal of the quality initiative is to have 60% of the assigned enrollees actively engaged within 90 days of assignment.

Using a "lean" problem solving approach and tools, CHL Community Partner program staff and managers will use idea systems to solve small engagement process problems and will work with the Quality Resource Group to develop PDSA cycles to develop standard work for the engagement process by on the ongoing assessment of the data related to the key success measure.

3. Functions of quality committee

The Senior Leaders and Clinical Policies & Operations Committee (CPO) both provide ongoing operational leadership of continuous quality improvement activities at CHL. Both groups meet at least monthly or not less than ten (10) times per year. The Senior Leader group consists of Vice Presidents and other executive level leaders. CPO consists of senior leaders and clinical managers from throughout the organization. The responsibilities of these Committees include:

- Developing and approving CHL's True North Scorecard (Organization's strategic goals and metrics).
- CHL Quality Management Plan (As part of the Plan the establishment of measurable objectives based upon priorities identified through the use of established criteria for

improving the quality and safety of clinical services).
- Developing indicators of quality on a priority basis.
- Periodically assessing information based on the indicators, taking action as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality.
- Establishing and supporting specific quality improvement initiatives.
- Reporting to the Board of Directors on quality improvement activities of the organization on a regular basis.

The Board of Directors also provides leadership for the Quality Management process by:
- Supporting and guiding implementation of quality improvement activities of the organization.
- Reviewing, evaluating and approving the Quality Management Plan annually.

Leaders, through a planned and shared communication approach, ensure the Board of Directors, staff, recipients and family members have knowledge of and input into ongoing QI initiatives as a means of continually improving performance. This planned communication takes place through the following methods;
- Annual dissemination of CHL True North priorities and Scorecard
- Participation in program QI projects
- Management participating in the CPO Committee reporting back to recipient groups
- Sharing of the clinic's annual QM Plan evaluation
- Newsletters and or handouts
- Visual Management Systems and tools such as story boards, A-3s and other posters displayed in administrative offices and common areas.

J. Coordination with ACOs and MCOs

1. Communicating skills and expertise to potential ACOs and MCOs

We plan to use a multi-pronged approach to ensure that all ACOs and MCOs in the Worcester and Gardner-Fitchburg Service Areas are aware of our skill, expertise, and value.

Through face-to-face introductory meetings, we plan to both learn about each ACO and MCO's particular needs as they relate to Behavioral Health Community Partners (BHCPs) and share with the ACOs and MCOs information about who we are and the ways in which we can help meet their needs.

Through written materials such as brochures and pamphlets, we will provide attractive, easy-to-understand information about how the ACOs and MCOs can benefit from a relationship with CHL.

We also plan to create a website that will provide similar information with an easy-to-remember address – so ACOs and MCOs will find it easily.

2. Branding and marketing plans

Our branding and marketing plans to ACOs and MCOs are in their nascent stages, but will build on the simple idea that as a BHCP, Community Healthlink is "here to help." We want ACOs and MCOs to know that we see our role as one that is essential not only to helping them provide the very best care for their patients, but essential to helping them provide the very best care for their patients with the most ease.

3. Strategy to engage with multiple ACOs and MCOs

As one of the largest and most comprehensive behavioral health service providers in Massachusetts, we have a rich history of working with an array of different types of partners in care. We recognize that although the basic structure of two organizations might be similar, in practice our relationship with each will be distinct from the other.

In order to engage and collaborate with multiple ACOs and MCOs in the Worcester and Gardner-Fitchburg Service Areas, we plan to hold introductory meetings with the administrative teams of each of the ACOs and MCOs to learn about their health care services and each organization's distinct needs.

We pride ourselves on being flexible and responsive in collaborative relationships, and that will be no different with this model.

4. Strategy for conflict resolution with ACOs or MCOs

CHL has been collaborating with other health care organizations across our service area for decades. We have worked with other organizations to solve conflicts related to everything from clinical matters to payment structures. With regard to ACOs or MCOs, if our program staff aren't able to resolve an issue with the front line staff of an ACO or MCO, we expect each entity to use program supervisors to try and eliminate the conflict.

Each contract that CHL signs with an ACO or MCO will have conflict resolution language agreed upon by both parties. Typical conflict resolution processes we engage in allow for a process that begins with meetings between the two parties and can end in arbitration if absolutely necessary.

With regard to the Tufts Health Public Plans, Inc and Central Massachusetts Accountable Care Organization ACO, of which we will already be a partner, we will use the governing structure of the ACO to help resolve conflicts. For issues that can't be resolved at that level, we will use the ACO's Behavioral Health Advisory Committee. The ACO's Joint Operating Committee will be the final arbitrator of conflicts that cannot be resolved at lower levels.

Community Partner Program Budget Report

		Eliot Community Human Services					
Program Revenue	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
Estimated Enrollees- Start of Period (All Enrollees)		2,000	2,500	3,500	4,000	5,000	
Estimated Enrollees - End of Period (All Enrollees)		2,500	3,500	4,000	5,000	6,000	
Estimated Enrollees - Monthly Average (excl CBFS enrollees)		1,200	2,200	2,700	3,800	4,800	
Estimated Enrollees - Monthly Average (CBFS enrollees only)		1,000	1,000	1,000	1,000	1,000	
Estimated Program Revenue (excl CBFS enrollees)		$ 1,512,000	$ 4,752,000	$ 5,832,000	$ 8,208,000	$ 10,368,000	$ 30,672,000
Estimated Program Revenue (CBFS enrollees only)		$ 1,750,000	$ 3,000,000	$ 3,000,000	$ 3,000,000	$ 3,000,000	$ 13,750,000
Total Estimated Program Revenue		**$ 3,262,000**	**$ 7,752,000**	**$ 8,832,000**	**$ 11,208,000**	**$ 13,368,000**	**$ 44,422,000**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -	$ -	$ -	$ -
Revenue for Operations		**$ 3,262,000**	**$ 7,752,000**	**$ 8,832,000**	**$ 11,208,000**	**$ 13,368,000**	**$ 44,422,000**

	Program Expenses		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
1	**Salary**		$ 215,833	$ 2,609,250	$ 5,445,000	$ 5,665,250	$ 7,040,550	$ 8,722,500	$ 29,698,383
2	**Fringe**		$ 21,583	$ 695,800	$ 1,452,000	$ 1,599,600	$ 1,987,920	$ 2,093,400	$ 7,850,303
	Total Personnel Costs		$ 237,417	$ 3,305,050	$ 6,897,000	$ 7,264,850	$ 9,028,470	$ 10,815,900	$ 37,548,687
3	**Training & Professional Development**		$ -	$ 7,263	$ 15,150	$ 18,300	$ 22,200	$ 24,300	$ 87,213
4	**Travel**		$ 1,610	$ 145,250	$ 303,000	$ 366,000	$ 444,000	$ 486,000	$ 1,745,860
5	**Equipment**			$ 4,842	$ 10,100	$ 12,200	$ 14,800	$ 16,200	$ 58,142
6	**Supplies**		$ -	$ 12,104	$ 25,250	$ 30,500	$ 37,000	$ 40,500	$ 145,354
7	**Contract Services** (consulting, professional)		$ -		$ -	$ -	$ 15,000	$ 80,000	$ 95,000
8	**Software licensing**					$ 115,200	$ 61,200	$ 61,200	$ 237,600
9	**Telecommunications**		$ 1,260	$ 6,600	$ 8,000	$ 9,250	$ 12,000	$ 11,600	$ 48,710
10	**Occupancy** (rent, utilities, maintenance)		$ 8,000	$ 87,500	$ 300,000	$ 325,000	$ 350,000	$ 375,000	$ 1,445,500
11	**Other**		$ -	$ 29,604	$ 55,250	$ 60,500	$ 67,000	$ 70,500	$ 282,854
	Total Direct Costs		$ 248,287	$ 3,598,213	$ 7,613,750	$ 8,201,800	$ 10,051,670	$ 11,981,200	$ 41,694,920
12	**Indirect Cost/Administrative Overhead**	**11.5%**	**$ 28,553**	**$ 413,794**	**$ 875,581**	**$ 943,207**	**$ 1,155,942**	**$ 1,377,838**	$ 4,794,916
	TOTAL EXPENSES		$ 276,840	$ 4,012,007	$ 8,489,331	$ 9,145,007	$ 11,207,612	$ 13,359,038	$ 46,489,835
	Surplus/Shortfall		*$ (276,840)*	*$ (750,007)*	*$ (737,331)*	*$ (313,007)*	*$ 388*	*$ 8,962*	*$ (2,067,835)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Program Director	$ 90,000	2	1.5	$ 22,500
Nurse	$ 80,000	8	1	$ 53,333
Clinical Care Manager	$ 70,000	4	1	$ 23,333
Care Coordinator	$ 50,000	24	1	$ 100,000
Engagement Specialist	$ 50,000	4	1	$ 16,667
				$ -
				$ -
				$ -
				$ -
Total Salary (Program Budget Line 1)		**42**		**$ 215,833.33**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 215,833.33	10%	$ 21,583
Total Fringe (Program Budget Line 2)			**$ 21,583**

Total Personnel*	**$ 237,417**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

Program Director: Each Program Director will be a Senior Manager responsible for the implementation, startup, organization, and engagement process of the CP teams.

Nurse: The Nurses will be responsible for medication reconciliation, supervision, engagement with enrolleees, coordination with PCPs, oversight/completetion of comprehensive assessment and treatment plan, and coordination with other medical providers.

Clinical Care Manager: The Clinical Care Managers will provide supervision, support with care cooridnation, clinical guidance, clinical intervention, expertise within the behavioral health system of care, oversight/completetion of comprehensive assessment and treatment plan, and engagement with enrollees and providers.

Care Coordinator: The Care Care Coordinators will provide direct care coordination services to enrollees, work direct with an enrollee's treatment team, assist in the completion of the comprehensive assessment and treatment plan, engagment with enrollees,provide peer support when applicable, and interventions relation to treatment plan

Engagement Specialist: Each Specialist will provide active engagment to potential enrollees to explain CP services, ensure consitent understanding of ACO/CP processes, review choices of enrollment, and enroll individuals into the CP.

Eliot is estimating approximately 2,000 clients arereferred during the start of the service. The staffing above reflects 75% of Eliot's model staffing per 1,000 enrollees.It is anticiapted that the remaining 25% of staffing model will be hired during the first month of budget period 1 to ensure adequate staffing and adherence to Eliot's staffing model.

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost

	A	B	C	D	E	F
41						
42						
43	**Total Training and Professional Development**					
44	**(Program Budget Line 3)**					

Provide a description of each Training and Professional Development line item included in the table above:

Row 4 - Travel

	Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
78	Program Director	128	1	0.535	$ 68.48
79	Nurse	400	1	0.535	$ 214.00
80	Clinical Care Manager	400	1	0.535	$ 214.00
81	Care Coordinator	1600	1	0.535	$ 856.00
82	Engagement Specialist	400	1	0.535	$ 214.00
83					$ -
84				**Total Mileage**	$ 1,566.48

	Travel Expense Description	Cost
87	Total Mileage	$ 1,566.48

	A	B	C	D	E	F
88	Parking and tolls	$ 43.52				
89	Public transportation	$ -				
90	Enrollee travel	$ -				
91	**Total Travel**					
92	**(Program Budget Line 4)**	**$ 1,610.00**				
93						

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

Eliot has utilized our historical estimates for other program statups to estimate the range of mileage for new staff members in the prep budget period. We are estimating that some mileage expense will be related to training, meeting wtih ACOs, meeting with PCPs, meeting with internal Eliot resources, meeting with community programs, and engagement with enrollees.

Row 5 - Equipment

	Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost
114				
115				
116				
117				
118				
119				
120				
121	**Total Equipment (Program Budget Line 5)**			

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Total Supplies (Program Budget Line 6)			

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

	A	B	C	D	E	F
230	**Description of Software**	**Cost per License**	**# Licenses**	**Cost**		
231						
232						
233						
234						
235				**Total Software Licensing (Program Budget Line 8)**		

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

	Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
270	Cellular Phone Plan/Services	30	42	$ 1,260.00
271				
272				
273				
274				
275				
276			**Total Telecommunications (Program Budget Line 9)**	**$ 1,260.00**

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

This expenses is for mobile/ cell phone services for CP staff.

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent	6000	12	$ 72,000.00
Utilities	1400		$ 16,800.00
Repair and Maintenance	600		$ 7,200.00
			$ -
			$ -
Total Occupancy (Program Budget Line 10)			**$ 8,000.00**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

Eliot has plans to lease two properties for the intial prep budget period to support the CP teams during the start up and intial implementation phases. Eliot will be leasing the properties for one month during the prep budget period and we have included estimated utility and repai/maintenance costs for a one month period.

The total square footage in the budget is 6,000 sq feet. Our budget assumes that we will continue to hire staff beyond the 43 staff hired during the prep budget. It is not feasible to incrementally add square footage to a lease while hiring staff that will work in the space. The size of the space is to accommodate hiring of additional staff

through year 1.

Row 11 - Other

Other Direct Expense Description	Cost
Total Other (Program Budget Line 11)	

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	**11.50%**	**$ 28,553.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

The Agency's current allocation of indirect costs at 11.5% which is a calculation based on an analysis of our last 3 years of agency administrative expense as well as our projections for agency administration costs for the fiscal year. These costs include those non-program specific reimbursable resources necessary for policy making, management, oversight and administration of Eliot as a whole. In this category are general agency administrative expenses such as HR, Finance, Executive Management, and general infrastructure.

Community Partner Infrastructure Budget Report

ELIOT

	Infrastructure Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
	PMPM Infrastructure Rate		$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
	Engaged Enrollees		2,500	2,500	3,500	4,000	5,000	
	Estimated Infrastructure Funds		$ 1,750,000	$ 2,581,500	$ 2,162,580	$ 2,179,200	$ 2,356,800	**$ 11,030,080**
	At- Risk Withhold Rate			25%	44%	63%	81%	
	Withhold			$ 645,375	$ 951,535	$ 1,372,896	$ 1,909,008	**$ 4,878,814**
	TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 1,750,000	$ 1,936,125	$ 1,211,045	$ 806,304	$ 447,792	**$ 6,601,266**

	Infrastructure Investment Projects		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
	Technology								
1	**IT Staffing including Fringe**		$ -		$ 100,000	$ 100,000	$ 100,000	$ 110,000	**$ 410,000**
2	**Development Adaptation of EHR and/or Care Management System**		$ 80,000	$ 80,000	$ 120,000	$ 75,000	$ 50,000	$ 50,000	**$ 455,000**
3	**Technology for Service Delivery**		$ 15,000	$ 30,000	$ 50,000	$ 75,000	$ 50,000	$ 140,000	**$ 360,000**
4	**Other Technology Expenses**			$ 150,000	$ 100,000	$ 10,000	$ 10,000	$ 10,000	**$ 280,000**
	Total Technology		$ 95,000	$ 260,000	$ 370,000	$ 260,000	$ 210,000	$ 310,000	**$ 1,505,000**
	Workforce Development								
5	**Workforce Development staffing including Fringe**		$ -		$ 130,000	$ 130,000	$ 135,000	$ 135,000	**$ 530,000**
6	**Recruitment Expenses**		$ 16,000	$ 125,000	$ 125,000	$ 125,000	$ 125,000	$ 125,000	**$ 641,000**
7	**Training Expenses**		$ 1,500	$ 20,000	$ 50,000	$ 50,000	$ 50,000	$ 60,000	**$ 231,500**
8	**Retention Expenses**		$ -	$ 45,000	$ 391,000	$ 391,000	$ 700,000	$ 700,000	**$ 2,227,000**
	Total Workforce Development		$ 17,500	$ 190,000	$ 696,000	$ 696,000	$ 1,010,000	$ 1,020,000	**$ 3,629,500**
	Business Start Up Costs								
9	**Office Equipment (PBP & BP1 only)**		$ 25,000.00	$ 80,000.00					**$ 105,000**
10	**Office Furniture (PBP & BP1 only)**		$ 9,000.00	$ 80,000.00					**$ 89,000**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**		$ 276,840	$ 750,007	$ 737,331	$ 313,007			**$ 2,077,185**
	Total Business Start Up Costs		$ 310,840	$ 910,007	$ 737,331	$ 313,007			**$ 2,271,185**
	Operational Infrastructure								
12	**Operation Staffing including Fringe**			$ 81,000	$ 160,000	$ 200,000	$ 200,000	$ 200,000	**$ 841,000**
13	**Other Operational Expenses**		$ 8,800	$ 205,963	$ 405,000	$ 405,000	$ 535,000	$ 585,000	**$ 2,144,763**
	Total Operational Infrastructure		$ 8,800	$ 286,963	$ 565,000	$ 705,000	$ 735,000	$ 785,000	**$ 3,085,763**
14	**Indirect Cost/Administrative Overhead Rate**	11.5%	$ 17,860	$ 103,151	$ 187,565	$ 191,015	$ 224,825	$ 243,225	**$ 967,640**
	TOTAL INVESTMENTS		**$ 450,000**	**$ 1,750,121**	**$ 2,555,896**	**$ 2,165,022**	**$ 2,179,825**	**$ 2,358,225**	$ 11,459,089

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
	$ -			$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary			$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Purchase of Care Management Platform	$ 80,000.00

	A	B
34		
35		
36		
37		
38		
39	**Total Development and Adaptation of EHR and Care**	
40	**Management System**	$ 80,000.00
41	**(Infrastructure Budget Line 2)**	

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Eliot has purchased eHana's Care Management Platform to ensure full integration with out current eHanna EMR. The eHana platform will ensure Eliot is able to meet all of integration and technology goals we set for our CP service.

Row 3 - Technology for Service Delivery

Description of Expense	Cost
Mobile Technology	$ 15,000.00
Total Technology for Service Delivery	$ 15,000.00

	A	B	C	D	E	F	G
67	**(Infrastructure Budget Line 3)**	$ 15,000.00					

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Eliot has budgeted $15,000 for the purchase of mobile technology for the 38 full time employees we plan to hire during the prep budget period. This technology includes the purchase of encryted chromebooks for each of staff members as well as a number of desktop computers for our CP hub offices. . It is estimated that we will purchase 6 desk tops computers which will cost approximately $4,800 and 32 Chrome Books whcih will cost approximately $10,200.

Row 4 - Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses (Infrastructure Budget Line 4)	

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 6 - Recruitment Expenses

Description of Expense	Cost
Recruitment and sign on bonuses	$ 16,000.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 16,000.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

We have budgeted $16,000 for recruitment and sign on bonuses based on our analysis of recruitment costs over the last two years. Eliot will be utilizing a sign on bonus for Nurses and Clinical Care Managers to assist in our recruitment efforts in a competetative hiring market for qualified licensed individuals. Eliot will also implement a multimedia recruitment effort .

The expenses are anticipated to break out as follows $2,000 for 2 regional job fairs . All other multimedia recruitment will be absorbed through Eliot's current recruitment budget. The remaining $14,000 will be used for recruitment bonuses . $10,000 will be provided to Clinical Managers (approximately $750 per position.) $4,000 will be provide d to Nurse Managers (approximately $1,000 per position).

Row 7 - Training Expenses

Description of Expense	Cost
Training	$ 1,500.00
Total Training Expenses (Infrastructure Budget Line 7)	**$ 1,500.00**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Eliot has a robust training department and we have done signficnat work to develop training material for our CP services. We anticipate training 38 staff members in the prep budget period at a cost of $1,500. This expense will mainly be utilized fo development of program specific traiing and orientation.

Row 8 - Retention Expenses

Description of Expense	Cost

	A	B	C	D	E	F	G
199							
200							
201							
202							
203							
204	**Total Retention Expenses**						
205	**(Infrastructure Budget Line 8)**						
206							
207	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms***						
208	***of the CP's contract and how the costs were determined:***						
209							
210							
211							
212							
213							
214							
215							
216							
217							
218							
219							
220							
221							
222							
223	**Community Partner <u>Infrastructure</u> Budget Report - Business Start Up Costs - Prep Budget Period**						
224							
225	**Row 9 - Office Equipment**						
226	Description of Expense	Cost					
227	Printers/Telecommunications Systems	$ 25,000.00					
228							
229							
230							

	A	B	C	D	E	F	G
231							
232							
233	**Total Office Equipment**	**$ 25,000.00**					
234	**(Infrastructure Budget Line 9)**						
235							
236	***Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were***						
237	***determined:***						
238							
239	We have budgeted $25,000 for the purchase of phone systems and multipurpose printers for our two CP offices in the prep						
240	budget period. These costs are based on our previous expereinces of program startup. Approximately $5,000 is allocated for 10						
241	printers and the remainining $20,000 is allocated for telecommunnication systems. This includes 38 handsets , wiring and						
242	installation. It is estimated that handsets will cost approximately $6,000 and the remaining $14,000 will be spent on wiring/						
243	installation.						
244							
245							
246							
247							
248							
249							
250							
251							
252	**Row 10 - Office Furniture**						
253	Description of Expense	Cost					
254	Desks/Chairs/Tables	$ 9,000.00					
255							
256							
257							
258							
259							
260	**Total Office Furniture**	**$ 9,000.00**					
261	**(Infrastructure Budget Line 10)**						
262							
263	***Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were***						

determined:

We have budgeted $9000 for the purcahse of our intial office furniture for the 38 staff members we anticpate hiring in the prep budget period. This will include desks, chairs file cabinetss, tables and bookcases . It is estimated that Eliot will spend approximately $4,000 on chairs , $2500 on desks, $2000 on tables and $500 on file cabinets.

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe (Infrastructure Budget Line 12)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 13 - Other Operational Expenses

Description of Expense	Cost
Marketing	$ 5,000.00
Legal Fees	$ 3,800.00
Total Other Operational Expenses (Infrastructure Budget Line 13)	**$ 8,800.00**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

We have budgeted $5,000 for the prep budget period to develop marketing materials for Eliot's CP service. We anticipate that our intial investment in marketing materials will assist enrollees inthe prep budget period with understanding how Eliot's CP can assist them in navagating the healthcare system.
Marketing materials will consist of brochures and informational material outlining the Eliot's BHCP service , related services and collaborating partners. In addition, Eliot will be updating our website to incorporate BHCP Services . It is anticiapted that approximately $3,000 will be used for Brochures and $2,000 for the website.

We have budgeted $3,800 for legal fees, to assist Eliot in finalizing contracts with ACOs, meeting HIPPA and PHI requirements, and

We have budgeted $3,800 for legal fees to assist Eliot in finalizing contracts with ACOs, meeting HIPPA and PHI requirements, and other complaince issues.

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**11.50%**	**$ 49,696.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined: The Agency's current allocation of indirect costs at 11.5% which is a calculation based on an analysis of our last 3 years of agency administrative expense as well as our projections for agency administration costs for the fiscal year. These costs include those non-program specific reimbursable resources necessary for policy making, management, oversight and administration of Eliot as a whole. In this category are general agency administrative expenses such as HR, Finance, Executive Management, and general infrastructure.

	A	B	C	D	E	F	G
358							
359							
360							
361							
362							

Community Partner Infrastructure Allocation Worksheet

	Insert Contractor Name Here						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 1,750,000	$ 1,936,125	$ 1,211,045	$ 806,304	$ 447,792	$ 6,601,266
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL INVESTMENTS	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Development and Adaptation of E.H.R/Care Management System	Implementation of Care Management Platfrom	10/01/17	05/31/18	User Acceptance and planning for training				Platfrom is live and used by Eliot's CP staff			
Technology	Technology for Service Delivery	Purchase tablets and/or laptops for CP staff as well as medication monitoring and pill dispenser equipment	02/01/18	05/31/18	Purchase laptop and or tablets for staff that have been hired.				Staff have access to electronic devices for mobile computing and a supply of medicationmonitoring and pill dispenser devices are available and ready to deploy.			
Technology	Development and Adaptation of E.H.R/Care Management System	Direct Connectivity between eHana and MassHiway	12/01/17	12/31/17	Connectivity complete				Connectivity Complete			
Technology												
Workforce Development	Recruitment Expenses	Implement a comprehensive recruitment strategy that includes sign on bonuses as well as multimedia recruitment campagain.	01/15/18	05/31/18	Bonus structure is advertised and utilized and recruitment campaign is fully implemented.				At least 42 FTEs have been hired for program start up.			
Workforce Development	Training Expenses	Development of Training ciriculuum specific to Care Coordination and other aspects of the the CP program as well as other related in house training and orientation.	01/01/18	05/31/18	Development of program specific training curiculum and orientation materials.				All staff trained in curiculum and reference materials available as a resource.			
Workforce Development												
Workforce Development												
Business Start Up Costs	Office Equipment	Purchase office equipment needed for program start up.	12/01/17	05/31/18	Purchase telecommuhnication system as well as printers for program operations				Telecommunication system and printers are operable and ready for use.			
Business Start Up Costs	Office Furniture	Purchase desks and chairs and other related office furniture for go live date.	12/01/17	05/31/18	Purchase desks, cahirs and othere related office furniture.				Furnture is installed and ready to use.			
Business Start Up Costs	Ramp-up Costs	The program will be staffed with a totally of 38 FTE as outlinned in the PBP Budget Narrative	11/01/17	05/31/18	2 Program Directors hired				42 FTEs are hired and ready to engaged and serve referred clients on 6/1/18.			
Business Start Up Costs	Ramp-up Costs	Office space is set up and fully functional for program start up.	11/01/17	05/31/18	Location and any plans for necessary modifications are identified				Space is completely set up and functional for program start-up.			
Operational Infrastructure												
Operational Infrastructure	Other Operational Expenses	Marketing Firm assit with updating website, branding,and marketing materials	11/01/17	05/31/18	Website Updated to include BHCP program as well as marketing materials and brochures available.				A marketing and branding plan is dveloped for implementation in budget period 1.			
Operational Infrastructure	Other Operational Expenses	Develop MOU, communication systems and other legal agreements with ACO and MCOs that is reviewed and approved by Legal Council	11/01/17	05/31/18	MOUs with ACO and MCOs fully executed.				Agreed upon communication systems as well as sharing of data is in place with ACO/MCOs			
Operational Infrastructure												
Operational Infrastructure												

BH Community Partner - Staffing Model

Insert Contractor Name Here

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	2500	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	3	*Total management oversight of BH CP*
3	Medical Director	0.5	*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs	10	
5	Clinical Care Managers (RN)	4	*Do not include FTEs listed in line 4*
6	Clinical Care Managers (LPHA)	14	*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders		*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff		*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	45	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)		*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists	7	
12	Administrative Support		
13			
14			
	Total FTE	83.5	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1:178	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	1:03	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff: Care coordinator staff will have direct supervision from Clinical Care Managers (

Behavioral Health Community Partners

Section 7.3 Initial DSRIP Participation Plan

A. Executive Summary

Eliot is an organization that is constantly on the move; expanding and retooling services to further its mission and values. We are passionate about improving the quality of lives for the people we serve which fuels our dedication to continuous service improvement, evidence based practice and program enhancement. It is through this construct that Eliot embraces the new Medicaid care delivery system in Massachusetts. Eliot has developed a comprehensive business plan for implementation and sustainability of the Behavioral Health Community Partner program that encompasses organizational change in tandem with community engagement, coordination and partnership.

As an organization that does not sit still, Eliot has woven together and incorporated many of the threads of the evolving health care system into its existing programs. Building on this process, Eliot is steadfast in its commitment to developing a state-of the-art Behavioral Health Community Partner program with an overarching goal of improving the lives of the people we serve through improved health outcomes, recovery and resiliency. This goal is achievable in an environment where consumers, health care, and community service providers partner together with a shared vision and mission. Eliot will meet this goal through implementing clear and detailed plans for ACO, MCO and consumer and community engagement, IT and communication infrastructure, data collection and analytics, protocols for information sharing and service delivery expectations. We know this process will be challenging. However, using the Commonwealth's vision for the Medicaid health care system as a framework for system and organizational integration will propel partnerships and collaborations.

Eliot is proposing a comprehensive holistic behavioral health case coordination service to serve individuals with SMI and/or SUD in the Somerville, Revere, Beverly, Gloucester, Lowell, Lynn, Malden, Salem, Woburn, Framingham, and Waltham Service Areas. Eliot has selected these service areas based on our experience and knowledge of serving individuals in these communities and relationships with other service providers, social service agencies and community partners in many of these cities and towns. We have built a program model that will serve at least 6,000 individuals across the aforementioned service areas. While we are able to serve at least 1000 individuals in each area, for planning purposes, we have built a model based on serving at least 6,000.

Eliot's business plan and preparations will begin upon submission of this proposal. Prior to the selection and contract negotiations, Eliot will begin the process of restructuring its Behavioral Health Division to align all services in a regional approach to service delivery. This approach will

strengthen our service access, integration and eliminate duplication and redundancy. We will also participate in eHana's Care Management Steering Committee providing input and feedback related to platform architecture. Senior management and executive staff will also further our discussions with potential ACOs, MCOs and community partners. In addition, Eliot will bolster its administrative infrastructure by hiring a Behavioral Health Project Manager and additional Quality Assurance staff. These positions will assist executive and senior management with all activities related to program start up and implementation. The Project Manager will be responsible for coordinating all communication and meetings with ACOs, MCOs and other community providers. Eliot will also begin meeting with our Consumer Advisory Board to assist with program planning and implementation. We believe this Advisory Board will be extremely important in providing input for program development, consumer engagement and outreach, as well as the development of branding, marketing materials and social media. We know that timely and active engagement will be extremely important to the success of this program and improved health outcomes for the people we serve. Continuous analysis of service gaps will be a crucial component of successful engagement, integration and service delivery. To that end, Eliot will provide employees with "service dashboards" to track specific sets of data that inform services. This will ensure our leadership team can redeploy and refine services in a proactive and fluid manner.

Upon award, Eliot will immediately begin to complete the tasks outlined in the Implementation Plan and Timeline. For the first year of the contract Eliot will devote the preparation time and first budget year to hiring and training qualified staff, outlining and monitoring program benchmarks and expectations, developing and refining billing, reporting and other administrative functions, intensive marketing, implementation of care management software, consumer engagement, and communication systems with ACOs, MCOs and other service providers. The focus of this time period will be seamless implementation and building a lasting foundation for program success and effectiveness.

In subsequent years, Eliot will seek to build on the foundation of the first year of operation. Much will be learned through the first year that will inevitably shape future years. Through analysis of program utilization, engagement, population demographics, Eliot will identify best practices and potential barriers. It is anticipated that our analytic capacity will develop and evolve over the course of time. As our IT systems become more enhanced and our staff become more accustom to service delivery our services will develop and thrive. We believe that each year will be a building block to a more refined system of care that will meet quality indicators and outcome measures which will provide a clear path to recovery.

B. Supporting Populations and Community Engagement

1. Current and Planned Connections to the Community

Eliot is devoted to maintaining and continuing the development of community connections; building sound partnerships to better support the people we serve and the larger community. Eliot has numerous long standing relationships with community based organizations, homeless and shelter providers, low income housing providers and housing authorities, social service organizations, substance abuse services providers, medical providers, and other behavioral health agencies. The chart below includes our current community partners:

Beverly
Acord food pantry, Beverly Bootstraps Food Pantry, Beverly Bootstraps, Greater Beverly YMCA, Beverly Council on Aging, NAMI Greater North Shore, Senior Care, Beverly Chamber of Commerce, North Shore Employment Collaborative, Beverly Hoarding Task Force, Beverly Housing Authority, Salvation Army, River House Men's Emergency Shelter, Beverly Hospital IOP, Harborside Counseling Services, Lahey SOAP/ IOP, North Shore Counseling Center, Beverly Hospital CHART for Risk/Case Management, Lahey Health
Framingham
Acton Food Pantry, Maynard Food Pantry, Open Table, Stow Food Pantry, First Parish Church of Stow, Town of Sudbury-Coordinator, Central Middlesex Police Partnership (CMPP), SMOC
Gloucester
Action Inc., Gloucester Housing Authority, CADA, Cape Ann YMCA, Open Doors, Cape Ann Social Club, Senior Care, North Shore NERLC Hub, Community Enterprises Inc. - ICE, Discover Program Addison Gilbert - IOP, Addison Gilbert Hospital CHART for Risk/Case Management, Day by Day, Gloucester Family Health, ABLE Home Health VNA Services, Grace Center, Safe Space, Gloucester High Risk Task Force
Lowell
Acton Community Supper/Food Pantry, Open Table, Verrill Farms, Bread and Roses, Corruum St. Patrick's, Gaining Ground Farm, Bread and Roses, Community Service Coordinator, Essex North NERLC Hub, NAMI Metrowest Area, New Beginnings, First Connections, AB Cares - Suicide Coalition, Communities for Restorative Justice Diversion Program, Council on Aging, Domestic Violence Services Network (DVSN), Central Middlesex Police Partnership (CMPP), CleanSlate, HKD Treatment Options, Lowell House, Smart Recovery, Stepping Stones, Concord Cares, Drop Off Swap Off, Household Goods Recycling of Mass, St. Vincent De Paul, Acton Housing Authority, Lazarus House, Lowell Transitional Living Center, Emerson Hospital - Addiction IOP, Oasis Program, Point After Club, Restoration Project
Lynn
Catholic Charities, East Coast International, First Church, ITDC, Lynn City Mission, Sacred Heart, Tree of Life, My Brothers Table, Centerboard, Lynn YMCA, Raw Art Works, Greater NERLC Hub, New American Center - Cultural Resources, Pyramid Builders Cultural Resources, Greater Lynn Senior Services, PACE /Element Care, HAWK, Bayridge Hospital - IOP, Adult Learning Center NSCC, North Shore Community College, Family Medicine, Medical Interpreters of the North Shore, Lynn Community Health Center, Healthy Streets, Project Cope, Steps to Solutions, Inn Transition Family Sober Living Program, Lynn Community Connections Coalition, Lynn Shelter Association, Massachusetts Coalition for the Homeless, Lynn Economic Opportunities
Malden
Arbour Counseling, CHA Central St. Health Care, Club 24, Healthy Me, Kelly House, North Charles INC, Saugus Spectrum, Learn to Cope, ABCD, Heading Home, Bread of Life, Wakefield Interfaith Food, CHA - HIPE - STD/HIV/AIDS, For Kids Only - Child Care and Resources for Parents, Metro North NERLC Hub, Outside the Lines, YMCA, One Everett - Cultural Resources, City of Everett, North Suburban Employment Collaborative, North Suffolk - IOP, Community Family, Saugus Physician Group, Salvation Army

Revere
Boston Healthcare for the Homeless, BU Center for Psychiatric Rehab, The Transformation Center, Salvation Army, Center House IOP, McLean Outpatient and Residential Services, Triangle Program/Arbour LGBTQ Partial Programming, Chelsea House, Commonwealth Land Trust, Dept. of Neighborhood Development, HEARTH Housing Homeless Elders, Lare Institute
Salem
CAB Health and Recovery, Inn Transition, Lahey Health, Salem Opioid Abuse prevention Collaborative, Community Healthcare, Danvers Community Council, Haven for Hunger, Middleton Food Pantry, Saint Josephs, Council on Aging, Salvation Army, Catholic Charities, RLC Hub, Danvers Jail Diversion Collaborative Meeting, Salem Police Mental Health Collaboration Meeting, Town of Danvers Veterans Affairs, North Shore Elder Services, Benchmark Senior Living, HAWK, Danvers Housing Authority, Peabody Housing Authority, Salem Housing Authority, Mass Coalition Homeless, Mission of Deeds, Victory Program (Serenity House) - HIV/AIDS Supportive Housing, Lifebridge, North Shore Community Action Program, North Shore Career Center, North Shore Chamber of Commerce, Peabody Chamber of Commerce, North Shore Medical Center - Partial Program, Salem Hospital IOP, South Bay Mental Health, Cape Ann Day Treatment, Rainbow Program
Somerville
Albany Street Shelter, Cambridge Multi Service, Cambridge Women's Center, City of Cambridge, Veterans Affairs, Cambridge Police, First Church Homeless Shelter, Harvard Square Shelter, Heading Home, New England Center for Homes, Phillips Brooks House Association, Somerville Homeless Coalition, St. Patrick's Women's Shelter, Transitional Age Youth Shelter, Acupuncture and Qigong for Health, Cambridge Health Alliance, Cambridge Health Care for the Homeless, Arlington Community Education, Cambridge Adult Learning, Cambridge/Somerville ESP, Clutter's Anonymous, Recovery Learning Center, STEPS, Jacob's Mother, Mass Alliance of Portuguese Speakers, Wicked Sober, First Parish Unitarian SMART Recovery
Waltham
AANE (Asperger's/Autism Support Network), DBSA, Kosher Table JFCS, Perkins School for the Blind, Waverly Place - McLean
Woburn
Bedford Youth & Family Services, Youth and Family Services, Community Table Pantry, Lexington Food Pantry, People Helping People, Inc., Cooperative Elder Services, Central Middlesex Police Partnership (CMPP), Middlesex Recovery Center, CSAC MAT, Lahey Burlington, Mission of Deeds, Covenant for Basic Needs

2. Growing Community Connections

We have seen firsthand the positive impact of our community partnerships and we plan to continue the growth of these connections. Eliot will utilize its marketing strategy, current connections, and sustained outreach to new partners to build upon our robust network. We plan to make each of our CP hubs resource centers to the community and will offer community education and community behavioral health supports. Additionally, we plan to involve our CP staff members in the development and growth of these partnerships by demonstrating the value to the enrollees and the services we provide. We are committed to growing these relationships to ensure a more efficient, focused, and supportive CP program.

3. Ensuring Staff are Informed of Community Resources

Access to our community resources is available to all of staff through our shared G Suite system and all additions are immediately shared with all staff members. CP staff/teams will be trained on use of this system.

C. Community Partner Supports and Activities

1. Outreach and Active Engagement

The most important principle of Eliot's Community Partners Teams is developing an engagement strategy with each enrollee that leads to a lasting and sustainable therapeutic connection. We have found that most behavioral health consumers have experienced a fragmented system of care and often do not obtain the access to services they need to improve their overall wellbeing. Given this experience of fragmentation, these individuals with comorbid behavioral health and medical conditions have reduced health outcomes.[i] Through our experience with the SPMI population, we have learned the techniques and evidenced based practices to ensure engagement. Motivational Interviewing (MI) is at the cornerstone of all aspects of our outreach, engagement, and care coordination for enrollees. We set out to discover with enrollees what they want, and we listen to their desires for treatment to ensure successful outreach and engagement with all individuals.

a. Strategies for Outreach and Engaging Assigned Enrollees

Recent research has demonstrated emerging practices focused on overcoming barriers to engagement strategies in care coordination programs.[ii] Specifically, relationship building with enrollees is paramount to effective care coordination. At Eliot, our feet-on-the-street approach to care coordination engagement not only embraces the current research, but is the backbone to all of our work with individuals and families in all of our programs. Eliot's CP teams are designed to meet the specialized needs of every community we will be operating within. We are committed to serving all assigned enrollees: enrollees who have not had success with traditional services, have had significant hospitalization, are homeless, have a substance abuse disorder, and those who have involvement in the criminal justice system. Our success in developing and building a relationship with enrollees starts upon enrollment and quick, sustained, and supportive engagement to ensure a solid foundation for a longer relationship with every enrollee.

Upon receiving information on an assigned enrollee, within 72 business hours, Eliot's CP Engagement Specialists will begin outreaching and engagement strategies. Engagement Specialists will meet enrollees where they are; meeting potential enrollees in our office will be the exception, not the rule. Our protocol and procedures, starting within 72 hours, will include face to face outreach attempts, phone calls, emails, text messages, social media, other electronic methods, and face to face meetings to engage a potential enrollee. We will also utilize both our extensive service system as well as the service systems of our partners and enrollee's current service providers to outreach and engage enrollees.

Our Engagement Specialists will outreach and engage enrollees at their places of residence. This may include shelters, inpatient settings, community settings, friend's residences, or other places where the enrollee is comfortable. Our protocol ensures that our Engagement Specialists make a sustained effort to meet every enrollee face to face within 7 days of assignment with the goal of demonstrating to the potential enrollee our CP teams are a fundamental support to assist the enrollee in improving their health. Understanding that all potential enrollees are unique, our Engagement Specialists procedures will be flexible to ensure each person receives the outreach and engagement that works for their preferences. To this end, our goal will be to meet face to face with every assigned enrollee at least once in the first thirty days, with sustained attempts at face to face meetings weekly, and no less than one attempt in the first 3 months of assignment.

We have a profound understanding of the SPMI population, individuals and families living in homelessness, and those individuals that are hard to reach or may be suspicious of providers. The most important principle of Eliot's CP teams is developing an engagement strategy with each individual that leads to a lasting and sustainable therapeutic connection. We have found that most individuals in these aforementioned populations are often the consumers that many providers do not fully understand or find it difficult to serve. At Eliot, we have developed an engagement strategy focused on meeting individuals where they are literally "at". We have learned that these individuals have strengths that are often unrecognized by other providers, and our Engagement Specialist will utilize these strengths to develop the basis for CP services.

b. Strategies for Outreaching and Engaging Assigned Enrollees with Substance Abuse

Eliot recognizes and plans to provide CP care coordination to a high percentage of enrollees with substance use disorders. Eliot's Engagement Specialists will utilize motivational interviewing to empower enrollees to engage in Community Partner care coordination no matter the extent of the current substance abuse or history of abuse. We fully embrace the Stages of Change approach to substance abuse treatment and we see our CP teams as critical in improving the health of this population. To this end, we will employ Engagement Specialists that are Recovery Coaches who will solely focus on outreaching and engaging this population. While our protocols and procedures for other enrollees will be the same, we believe having Recovery Coaches providing the early engagement to these enrollees will be key in successfully serving this population.

We have utilized Peer Specialists and Recovery Coaches in other Eliot services and programs, and we have seen firsthand the success of this evidence based approach. This strategy gives our Engagement Specialists and the enrollees the opportunity to explore their motivations for

change and to develop supportive therapeutic connections. We understand that enrollees with substance abuse disorders are often ambivalent about making changes in their lives regarding substance use. Often, an individual expresses a desire for change but is afraid to work towards that goal for a multitude of reasons. Our Engagement Specialists recognize the continuum of motivational readiness to change that an enrollee experiences, and focuses on the aspects of services, treatment or any goals the individuals would like to pursue. Through motivational interviewing engagement, Eliot has a proven track record of supporting individuals in making successful changes in their lives as part of the recovery process. In addition, Eliot has a fundamental belief in harm reduction techniques towards coordination and in providing services. Our approach, similar to the more general CP population, will be strength based and rely developing a therapeutic connection to each individual.

c. Processes for Documentation and Agreement of Enrollee Participation

Our Engagement Specialists will actively engage enrollees in conversations on the design, benefits, and supports of Eliot's CP teams. These conversations will occur face to face in whatever setting the enrollee prefers, through phone calls, electronic communication and social media. We understand that these conversations and communications will be the building blocks for the enrollees experience with our CP program and for us the entry point for forming a lasting relationship. To this end, we will utilize printed material to explain the CP program, mobile device videos/presentations, an interactive website, and social media to ensure flexible and relevant information on CP supports. We understand that communication and access are crucial to successful engagement and we will employ several strategies to ensure every enrollee has a method they can easily utilize with an Eliot CP. Along with face to face engagement, we will ensure every enrollee has their Engagement Specialist's phone number, email, and phone number for the Eliot CP hub. We will walk through the process of contacting and engaging the Eliot CP with every enrollee and provide them with quick and simplified material summarizing this process. As part of educating the enrollee on the engagement process and benefits of the CP, we will educate them on opting out of CP supports or obtaining a different CP provider. We will provide each enrollee with access to a patient portal.

Engagement Specialists will review and explain the Eliot CP agreement of services with each enrollee and obtain a signed participation form from those agreeing to services. Enrollees will be provided with a copy of the participation form and an electronic version will be placed in the Eliot record. The Engagement Specialist will also review the Eliot Privacy Notice and obtain relevant consents from the enrollee to obtain Protected Health Information (PHI) and contact providers and others the enrollee consents to having involved in their care coordination. The Engagement Specialist will review, and provide written material, with the enrollee on the uses

and disclosure of any and all protected information. Upon obtaining the enrollee's signed participation form, the Engagement Specialist will provide the enrollee with the contact information for the Eliot Care Coordinator. The Eliot Care Coordinator will contact the enrollee in no more than five business days. The Engagement Specialist and the Care Coordinator will work in tandem to continue to engage the enrollee in CP services.

2. Comprehensive Assessment and Person-Centered Treatment Planning

In Eliot's experience providing services to the SPMI population, we have learned that individuals do not respond well to clinicians or other staff members attempting to sit with them for long stretches of time to complete assessments. We have found that having a fluid approach to the assessment process both ensures well developed assessments and sustained connection between team members and a consumer. A growing body of research continues to demonstrate that assessments, treatment planning and interventions that only focus on the removal of symptoms falls far short of promoting mental health and recovery and reducing long term relapses.[iii] At Eliot, our assessment process includes multiple face to face contacts with an individual to complete one assessment and team members often engage in conversations with individuals that center around assessment topics rather than presenting the person with multiple questions. Based on the individual's goals for their life, their desires for treatment, and a recovery oriented assessment, a person-centered treatment plan can be developed that is person centered, time limited, measurable, observable, behavioral, realistic, and contains attainable goals and objectives. In a person centered environment we are exceedingly aware of the unique issues, life circumstances and values of each person we serve. To that end, all aspects of the assessment process and person-centered treatment planning process account for family structure, life style choices, culture, ethnicity, linguistic preferences, sexual orientation and gender. We foster an environment of acceptance which respects and values the unique heritage, background, lifestyle and experiences of everyone in services.

a. Process for Comprehensive Assessment

Eliot firmly believes that a sustained connection between an enrollee and the Care Team is the cornerstone of service delivery. Upon completion of a participation form, a Care Coordinator and a Clinical Care Manager will meet with an enrollee to identify the immediate needs of the individual, determining any urgent health or safety issues that will require immediate attention. A Crisis and Critical Risk Plan will be created that addresses the nature and intensity of serious health and/or safety risks as well as steps that should be taken to address these issues and

support the individual in managing their immediate goals. The Crisis and Critical Risk Plan will be shared with the enrollee's Care Team, ACO or MCO, and other providers as appropriate (*See Crisis and Critical Risk Plan in Attachments*). We believe that having an initial plan of care developed with the enrollee prior to the completion of the comprehensive assessment will not only support the enrollee's immediate goals and needs but will be vital to sustained engagement and the development of a meaningful comprehensive assessment.

After completion of the Crisis and Critical Risk Plan, the Care Coordinator will collaborate with the enrollee and other members of the Care Team in the completion of a comprehensive strengths-based assessment within 3 calendar months of enrollment. The Care Coordinator will work with other members of the CP team, such as Engagement Specialists, other Care Coordinators, Nurses, Peer and Recovery Specialists, and Clinical Care Managers to ensure continuity of care, direct involvement and feedback from the enrollee, and the incorporation of all relevant information. The assessment will be conducted face to face with the enrollee over several meetings and may include phone contact and use of other technologies such as secured email and patient portals. The enrollee will be central to the completion of the assessment and CP team members will utilize motivational interviewing techniques to engage enrollees to ensure their perspective is fully embraced within the assessment.

Members of the CP team will utilize their various expertise to engage the enrollee and gather relevant information related to their discipline. Peer and Recovery Specialists, trained in Whole Health and Action Management (WHAM), will obtain from enrollees their perspective on the 10 Resiliency Factors and ensure this is incorporated into the assessment.[iv] Information obtained utilizing WHAM will assist the team in best understanding the enrollee's strengths and current and past self-management tools. A nurse from the CP team will conduct a current Physical Health Assessment which will be incorporated into the Comprehensive Assessment and includes last medical visit and contact information for providers, current and past medication history, current and past medical conditions, family medical history, use of medical equipment and direct contact with medical providers.

The Care Coordinator and the Clinical Manager will focus their contributions of the assessment on all other aspects but not limited to history, functional status, mental health substance abuse, and care management needs. Enrollees will review the draft assessment with the Care Coordinator and the Clinical Care Manager to ensure the enrollees' participation is well reflected and to obtain their approval. The Clinical Care Manager will conduct the final review and approval of the comprehensive assessment. An example of the Eliot Comprehensive Assessment, leveraged from our current MSDP Comprehensive Assessment, is mapped to all CP requirements in the attachments (*See ACA in Attachments*). The approved Comprehensive

Assessment will be provided to the Care Team, relevant ACOs or MCOs, and other providers involved with the enrollee as appropriate. The Comprehensive Assessment will be updated on a minimum of an annual basis, however the CP team will updated the Comprehensive Assessment when the enrollee experiences significant changes in their life related to their behavioral health, medical conditions, wellness or other life circumstances.

b. Process for Person-Centered Treatment Plans

1. Development of Person-Centered Treatment Plan

The CP team will develop the Person-Centered Treatment Plan concurrently with the Comprehensive Assessment and will ensure the enrollees are at the center of the treatment plan and that the assessment is incorporated into the plan. Need areas are prioritized according to the enrollee's preferences, wellness goals, and life goals. The whole treatment planning process is a flexible and dynamic one which changes according to consumer needs and preferences. All Eliot Peer and Recovery Specialists have been trained in Intentional Peer Support (IPS) and this will extend to the CP teams. IPS is a well-developed peer and recovery approach where the notion of mutuality redefines interventions and help as a co-learning and growing process.[v] CP Peer and Recovery Specialists will utilize IPS techniques to engage enrollees in developing goals and also identifying barriers.

We foster an environment of acceptance which respects and values the unique heritage, background, lifestyle and experiences of each consumer. We encourage family participation in treatment planning and other aspects of service delivery with the goal of maintaining positive relationships and/or family reunification (as appropriate). We understand the cultural and ethnic influences that can impact service delivery, utilizing community organizations, our own staff, consumers, families and other sources to provide a comprehensive understanding. All assessment and treatment planning will be conducted in the enrollee's preferred language. To further our commitment to cultural and linguistically competent services we are able to translate all written documentation (treatment plans, assessments, service information) into the enrollee's preferred language. If an enrollee prefers or needs their treatment plan to be in a format other than writing, such as a recording or a video, Eliot will provide that to the enrollee. The enrollee, the CP team, Care Team members and other service providers, supports and family invited by the client, will meet to review the treatment plan prior to approval.

2. Documenting Person-Centered Treatment Plan

The initial Person Centered Treatment Plan will be completed in no more than 3 calendar months from enrollment. The CP team and Care Team interventions and supports are identified for each goal and the corresponding objectives. Interventions and supports outline the specific actions and frequency that the identified team member will need to support, encourage, and assist the enrollee in achieving treatment goals and objectives. In addition, the treatment plan will identify community linkages and other natural supports that may be utilized for goal attainment and support. Goals will be both long and short term and will focus on supporting the enrollee in managing their experiences of the complex medical and clinical conditions.

The process of evaluating the progress that has been made toward clearly defined goals is a collective and collaborative effort with the enrollee and the Care Team. The goal planning process forms the focus and basis for enrollee and team member's interactions. To that end, both the enrollee and Care Coordinator monitor functioning and discuss progress on a regular basis (*See Treatment Plan in Attachments*). The Crisis and Critical Risk Plan developed with the client during the early stages of enrollment will be reviewed with the enrollee and the Care Team at the time of documenting the treatment plan to also finalize the Crisis Plan.

3. Updating Person-Centered Treatment Plan

CP team meetings to review progress will occur at least quarterly. The enrollee will be encouraged to set the agenda for these meetings, rather than the team determining what will be discussed. This process allows the enrollee to receive immediate recognition and reinforcement for achievements and make modifications for plans that have not been completed. Eliot believes that this collaborative approach to monitoring the Person Centered Treatment Plan empowers the enrollee to assume self-monitoring and control of his or her plan. The Person Centered Treatment Plan will have quarterly objectives and bi-annual goals. CP team members will record progress, interventions, and barriers in monthly notes. Quarterly and annual reviews to the treatment plans will be documented to both acknowledge the progress but also to make revisions as needed. This documentation assesses the enrollee's progress toward meeting his or her goals and objectives, and evaluates the effectiveness of each intervention in the plan. CP team members will problem solve with the enrollee and Care Team members on barriers to achieving objectives and goals and find solutions to support the enrollee in being successful. This may include changes in the enrollee's functioning or medical conditions which impact the enrollee's progress in the treatment plan. When updating the

treatment plan, the Clinical Coordinator will collaborate with the enrollee and the Care Team to ensure all progress is reflected, current assessment of health functioning, update on goals/objectives, and developing an updated plan where applicable to support the enrollee. The treatment plan will be reviewed and updated no less than bi-annually.

4. Enrollee and PCP Approval

The enrollee will review and approve the treatment plan prior to finalization or distribution to any other members of the Care Team. The final version of the plan will be reviewed with the Care Team and will be approved by the enrollee's PCP. Any updates to the treatment will be approved by the enrollee and the PCP. The enrollee and the PCP will be provided copies of all treatment plans upon approval, including any and all updates to treatment plans. Additionally, the Eliot CP team will share the finalized treatment plans with the Care Team, ACOs or MCOs, and other providers involved in supports and treatment of the enrollee.

There is a growing body of research and evidence related to care coordination and care management in health to achieve the triple aim of improving quality, improving the health of populations, and reducing the cost of health care.[vi] Recent studies[vii] have demonstrated promising practices that Eliot will employ in our CP teams in their delivery of care coordination and care management including:

- Integrating care to achieve patient-centered health care,
- We will have developed flexible protocols and procedures to work with enrollees and stakeholders,
- Our CP teams will be comprehensive and robust to provide the foundation for integration,
- We will utilize continuous evaluation and change management to achieve outcomes, and
- We will use data collection to drive coordination improvement.

Our CP teams will focus on these five emerging best practices to develop a fully integrated Care Team that represents all of the stakeholders and providers involved in an enrollee's treatment and services.

3. Care Coordination and Care Management

a. Stakeholders Involved In Care

All members of Eliot's CP teams will utilize motivational interviewing techniques to engage enrollees in identifying all providers, family members, individuals, advocates, and other community supports involved in the enrollee's life to participate in an enrollee's Care Team. The CP Care Coordinator will provide care coordination by serving as the primary conduit to the larger Care Team ensuring that each member of the Care Team has an appropriately defined role and that all Care Team members' contact information is documented and shared. At a minimum, the Eliot CP team will ensure every Care Team includes the enrollee's PCP or designee, the Care Coordinator, the CP Clinical Care Manager, and behavioral health clinician(s). Additionally, our Care Coordinators will explore with enrollees their motivations to include family members, community supports, other clinical staff, other providers involved in care, State agencies or contracted services, and any advocates representing their interests.

b. Exchange of Information

The Eliot Care Coordinator working with each enrollee on the CP team will be the primary liaison in communicating and exchanging information with the stakeholders on the Care Team. Other Eliot CP team members will provide communication when their expertise is needed such as the CP nurses being involved in medical communication or the Clinical Care Manager taking a lead role in complex behavioral health conditions. The Care Coordinator will use all available technologies such as phone calls, text messages, emails, and patient portals to facilitate information exchange with the enrollee, the PCP, other providers, and any other individuals or providers on the Care Team.

In the event that an enrollee receives LTSS services, the Eliot Care Coordinator will provide the primary communication and coordination with any and all LTSS services. The Care Coordinator will actively work with the enrollee to ensure they receive information on LTSS services, are able to make informed choice on LTSS services and consistently have at least two choices of LTSS providers. The Care Coordinator will assist the enrollee in not only making choices regarding LTSS services but will also assist enrollee in accessing LTSS services. The Care Coordinator will document in the Eliot record the interaction with the enrollee on LTSS services. In addition to the Care Team and LTSS providers, the Care Coordinator and/or the Clinical Care Manager will communicate and exchange information, when applicable, with an ACO or MCO.

c. Identifying and Organizing Care Team

Each Care Coordinator, CP nurse, and Clinical Care Manager develops a therapeutic relationship with each of her or his enrollees to provide care coordination and care management related to all of the enrollee's services. We believe that it is essential that each Care Coordinator develops

a continuous and lasting therapeutic connection with each of his or her clients as this is an important building block within the CP model to ensure the enrollee is able to access all pieces of Care Team's services. The Care Coordinator is responsible for working with the enrollee to monitor her or his person centered treatment plan and to ensure that Care Team members are providing interventions that the enrollee finds helpful in achieving goals and improved health outcomes. To this end, the Care Coordinator will assist and advocate for the enrollee to receive access to primary care, specialty care, LTSS services, and behavioral health care. The Care Coordinator will convene regular care team meetings and communication with PCP, ACO and other service providers. The Care Coordinator will work with the CP nurse and the Clinical Care manager to ensure each enrollee understands both services available and recommendations from his or her PCP, specialists, and other providers. The Care Coordinator will provide assistance with scheduling appointments, accessing transportation, and reminders of appointments with any services of the Care Team. The CP team will also provide check-in calls, text messages, emails and face to face visits with the enrollee to assess and support their adherence to Care Team services and recommendations for treatment. The CP nurse and Peer Specialist will engage the enrollee on medication adherence and assist the enrollee in making a shared decision with all of the prescribers providing medications to the enrollee.

Eliot will ensure that enrollees feel true support by their CP team in their overall treatment with the Care Team. This will include the Care Coordinator advocating on behalf of the enrollee to the larger Care Team and ensuring that they are well represented in all aspects of treatment. The Care Coordinator will provide education to both the enrollee and to the Care Team regarding illness management and the needs for changes in treatment based on the enrollee's motivations and readiness to adhere to recommendations. Eliot will ensure that the multi-disciplinary Care Team is providing the support to an enrollee and ensures that an enrollee receives all available services. The CP team will keep the Care Team oriented to ensure that services are continuous, well-coordinated and lead to successful outcomes.

d. <u>Ensuring Effective Communication and Exchanging Documentation</u>

Eliot intends to leverage standardized technology frameworks to facilitate data exchange with EOHHS, ACOs, MCOs, and other stakeholders. eHana's Meaningful Use-certified EHR provides validated support for healthcare interoperability standards and standardized transactions formats. Eliot also recognizes that specific infrastructure and technology investments will be necessary to fully support the information sharing requirements of EOHHS and ACOs, including extracts and integrations. Technologies to be used to support care management include: Standards-based transactions including CCD over Mass HIway/Direct Project; Importing

eligibility files and enrollment rosters from EOHHS and ACOs; Bespoke reporting and data extracts in formats specified by EOHHS and ACO partners; Standardized HIPAA billing transactions (837p) of Qualifying Activities to EOHHS; Future use of EOHHS Event Notification System (ENS) or, where possible, event data integration directly with healthcare stakeholders. We will work closely with ACO partners throughout the Preparation Budget Period to determine mutually-agreeable datasets for information exchange to improve care coordination efforts. We also understand that a responsive, engaged Care Team is critical to running an effective care management program. Chat is a key emerging technology, both within and outside of healthcare; with enrollee-centered Care Team discussions, members can collaborate in individual enrollee "chat rooms" and track progress, while automated alerts and notifications provide additional context and prompt team member action. We will engage enrollees using mobile technologies, including smartphone applications. For highly engaged enrollees, mobile applications will provide a mechanism for communicating with the Care Team, tracking basic mood and other data, and alerting the Care Team of potentially adverse events.

4. Care Transitions

We know that public healthcare is often delivered in silos and that 20 percent of individuals discharged from hospitals have an adverse event within 30 days.[viii] Eliot is well accustomed to providing face to face supports to behavioral health clients during periods of transitions from emergency rooms, from acute psychiatric facilities, and from medical facilities. We have learned that being present with individuals during these periods not only provides them with feelings of support and care, but ensures that we can better provide interventions to support their community tenure and receive community and home based interventions to manage symptoms related to mental illnesses and/or medical conditions. Recent studies have demonstrated intervening at times of transitions with at least one home visit can reduce suicidal ideation[ix] and re-hospitalization due to a chronic medical condition[x]. Our Eliot CP teams will be present during all discharge and transitions of care to ensure an appropriate plan is developed and is well supported by the enrollee, the CP team and the Care Team.

Eliot's CP team staff members will be present at discharge planning meetings and depending on the nature of the transition, this may include multiple members of the team such as the Care Coordinator, the Clinical Care Manager or a nurse. At the time of discharge planning, the CP team will coordinate with the enrollee's PCP, ACO, MCO, and other providers and members of the Care Team. Knowing that transitions of care are crucial in reducing adverse outcomes, Eliot CP team members will provide every enrollee with a face to face follow up within 3 business days of discharge. The CP team will work with the enrollee to update their treatment plan to

ensure interventions and supports are in place to support the enrollee in staying in the community, rather than suffering from an acute episode. The CP team will ensure the updated person-centered treatment plan is shared and collaborated with the Care Team and the CP team will coordinate all medical, clinical and other supports for the enrollee. Post transition, the CP team will provide updates to the enrollee's PCP, the ACO and the MCO.

In the event an enrollee is not discharged from a hospital or treatment setting and is instead referred to other levels of care, other programs, an ACO or MCO, or any other provider, Eliot's CP team will provide the primary coordination and support to the enrollee. Eliot's CP team members will coordinate, and be present when appropriate, for face to face contacts with any new provider, program, service, or higher level of care and the enrollee. The Eliot Care Coordinator working with an enrollee will coordinate transportation and assistance so that the enrollee can attend any appointment, engage in a new service, or a new program. If an enrollee is unable to attend an appointment or misses a transition date, the Eliot Care Coordinator will follow up with the enrollee to either reschedule or find a new date for transition. When needed, the Eliot CP team will coordinate and share all records with the provider that the enrollee has been referred for services.

5. Medication Reconciliation

Eliot is committed to training enrollees to be self-medicating and learning to advocate for themselves to ensure their medications are effective, accurate and they are motivated to adhere to a medication regimen. To this end, an RN from the Eliot CP team will conduct medication reconciliation for enrollee's discharged from any type of inpatient setting or within at least 3 business days. This will include verifying medication orders and medication plans with an enrollee's PCP, medical specialists, behavioral health prescribers, and any other medication providers. The CP RN will meet face to face with the enrollee, coordinate with pharmacies, or service providers to verify discharge medications are filled properly. In the event that an enrollee receiving MAP supports or VNA services, the CP RN will share and coordinate medication orders between the PCP, other providers, and discharging hospital. Additionally, the CP RN will assess every enrollee's ability understand their medication regimen, non-adherence, discrepancies in medications, and any contraindications; this process will also occur at times of discharge from an inpatient setting. The CP RN will provide training to enrollees on self-medication and may utilize medication minders, medication dispensers, and specialty packing from pharmacies (Medication on Time, Bubble Packing etc.) to increase an individual's adherence and understanding of their medications. Training occurs at multiple levels depending on each enrollee's demonstrated skills and preferences, training will include:

- The name of each medication prescribed, dosage and frequency,
- The reason each medication is prescribed and common side effects,
- Advocacy skills to communicate medication effectiveness/usefulness,
- Skills to independently take medication, as prescribed,
- Remembering to refill medication before it runs out,
- The way to take medication responsibly and without misuse or abuse, and
- How to utilize supports when problems or concerns arise

The CP RN will utilize, and train if needed, other members of the CP team and supports from the Care Team to support an enrollee in understanding and adhering to their medication plan.

6. Health and Wellness Coaching

Eliot believes that the foundation of wellness and physical health begins with services, supports and environments that foster and promote healthy living. Eliot has established several wellness initiatives which have improved the overall wellbeing of the populations we serve and our workforce. These initiatives are guided by the Eliot Health and Wellness Committee which is comprised of the Eliot Medical Director, Program Nurses, an Eliot Nutritionist, Clinical staff, Peer Specialists, and clients. This committee meets monthly and provides a forum for those attending to discuss issues and concerns relevant to consumer nutrition, exercise, smoking cessation and other health areas. These meetings are opportunities to provide education on various health topics and help steer policies and practices related to wellness in all Eliot programs.

a. Health and Wellness Education, Coaching, and Promotion

Eliot recognizes that many CP enrollees are diagnosed with severe medical conditions requiring consistent monitoring and specialized treatment. We understand that prevention, wellness, and intervention are keys in supporting enrollees in improving their overall health and reducing time spent in emergency rooms and inpatient medical settings. Eliot will utilize Peer Support Whole Health and Resiliency (PSWHR), or WHAM, to provide enrollees with a person-centered MI approach to making positive health and wellness choices in their lives. All Eliot CP team members will be trained in PSWHR by Eliot's certified PSWHR trainers. PSWHR rests on three principles:

- Individuals do not make health or life-style changes when they feel coerced,
- Individuals are more likely to make healthier choices when MI is utilized and services focus on an individual's interest,

- Individuals are more successful at forming new habits and choices to make healthier choices rather than focusing on "bad" habits.

PSWHR includes comprehensively assessing an enrollee's health and life style choices, utilizing an enrollee's strengths and interests to make healthier choices, utilizes peer supports for motivation and encouragement, and creates resiliency in managing chronic illnesses. Eliot CP teams will offer PSWHR individual interventions as part of an enrollee's person-centered treatment plan and the CP teams will offer PSWHR groups at our hub offices focusing on the 10 week PSWHR curriculum.

In addition to utilizing PSWHR techniques and interventions, Eliot's CP teams will provide health education to enrollees on their medical conditions, on risk factors such as smoking, nutrition and the benefits of exercise. In the event an enrollee is in need of smoking cessation, the Eliot CP team will work with the Care Team or an Eliot smoking cessation group to provide the service to an enrollee. The CP team will collaborate and coordinate with an enrollee, when indicated, and the enrollee's PCP on weight loss and nutrition goals.

b. Tracking and Recording Goals for Health and Wellness Services

All goals, interventions, supports, and services related to health and wellness will be part of an enrollee's person-centered treatment plan at Eliot's CP programs. Health and wellness providers, beyond the Eliot CP team, will be incorporated into an enrollee's Care Team and communication, tracking, and sharing of information will follow the same process with other Care Team members. Eliot CP team members providing health and wellness education as well PSWHR interventions and supports will document and record services in the Eliot enrollee record. Recording and tracking will include participation in interventions, response to interventions, and progress towards health and wellness objectives and goals. This information will be shared by Eliot with the enrollee's PCP and other Care Team members as appropriate.

7. Connection to Community and Social Services

Eliot is committed to providing enrollees with support in both developing new community and social relationships and in sustaining existing community and social relationships. Addressing an enrollee's desires and needs in this area often is driven by the enrollee, the CP team, and the assessment process. We have learned that the relationships with Eliot staff become the conduit for individuals to pursue greater social connections and break feelings of isolation. Building social capital and encouraging participation in community life as a citizen - rather than as someone with multiple medical and behavioral health diagnoses - is an essential aspect of a person-centered approach to care. To that end, CP team members will provide interventions

and supports that occur in all parts of the enrollee's life environment and context. By providing face to face interventions in the community, at the enrollee's home or wherever services are needed, CP team members can have a better understanding of the individual. Face to face interventions will allow enrollees and CP staff to practice skills together and allow team members to tailor interventions in real time and in the context of the enrollee's social experience.

Eliot's CP team members will support enrollees in both developing new relationships and sustaining relationships. As part of the assessment and person-centered treatment planning process, CP staff will assist each enrollee in determine his or her desires and needs for increased social connection. In other services, we have seen an individual we are serving have goals solely focused on making new friends and building a larger social net of friends to support them. We know that the relationship staff members have with an enrollee can become the conduit for an enrollee to pursue greater social connections and break feelings of isolation. Building social capital and encouraging participation in community life as a citizen - rather than as a behavioral health consumer – will be an essential aspect of Eliot's CP services. CP interventions will focus on all parts of the enrollee's life environment and context. By providing side by side interventions in the community, at the enrollee's home or wherever services are needed, CP staff members can have a better understanding of the social needs and potential interventions. Often this includes assisting individuals in identifying or participating in leisure activities such as going to sporting events, museums, community centers, places of worship and other areas of interest. All CP team members will assist enrollees in developing skills related to developing and maintaining social relationships. This often occurs with individuals' families, friends, and other individuals the enrollee may identify. Behavioral health consumers often need support and assistance developing ways to communicate their feelings and accessing their wants and desires from those closest to them. We have found that by assisting consumers in building and sustaining these relationships with family and friends has a profoundly positive effect and can often change the trajectory of treatment in a positive direction.

D. Innovative Technologies for Service Delivery

At Eliot we have found that technologies can be a useful tool in supporting individuals with SPMI in maintaining their wellness and mental health stability and treatment in the community. Currently, we utilize several technologies in the community to engage individuals in treatment and we provide individuals with adaptive technologies. We have provided smart phones to some individuals who have had difficulty engaging in behavioral health services or suffer from severe isolation. The smart phones have allowed us to text and face time with these individuals to improve their engagement in services, provide follow up, and to provide remote interventions. We have also utilized various apps depending on the individual's need such as Pacifica which is a self-management tool to assist with Anxiety and Depression, Lantern which provides assistance with individuals engaged in CBT, and the Mood Network which allows people to communicate in an open forum on bipolar illness and other mood disorders to access supports.

We have also provided many individuals with electronic and automatic medication dispensers and medication reminder dispensers to assist them in adherence to a medication plan and to simplify the process. We have found that some individuals simply need assistance in preparing the medication reminder system. We also found some individuals need their medications dispensed to them and are unable to take their medications independently. For these individuals, we have utilized the Med Ready dispensers which automatically dispense medications. We have also partnered with several pharmacies on purchasing packaging systems that adapt to the needs of the people we serve. We have also used the Medication on Time system, which provides daily packed medications that are individually labeled so the people we serve do not have to pack and can easily access their medications.

We plan to continue to invest in tools to allow for protected telemedicine focused on behavioral health. We have contacted several vendors and we are in the process of demoing systems with Eliot providers. We also anticipate utilizing mobile apps to support CP staff the outreach process. We envision that these apps will identify enrollees requiring outreach and follow-up, and would be synchronized with the centralized eHana Care Management platform for review by Care Team members. We are also exploring leveraging social networking tools with enrollee consent, such as Facebook Messenger, to engage with enrollees. Techniques could include leveraging Facebook's Messenger Platform Application Programming Interface (API) to supply enrollees with our Eliot chat name as well as a unique code, which would automatically associate their Facebook Messenger account with their Care Management record. Enrollees and Eliot could maintain or initiate contact at any time via the Messenger app already installed on their phone

E. Personnel and Staffing

1. Organizational Chart and Personnel Responsibilities

Eliot's commitment to infusing clinical expertise into its services is unsurpassed in the community behavioral health arena. Clinicians are integrated throughout our service delivery structure at multiple levels in order to provide supervision and to provide services. The Eliot CP model provides an ordered balance and mix between clinicians, medical staff, engagement workers, those with lived experience, specialized staff, and care coordinators. Our system is predicated on team members working collaboratively with enrollees to meet their unique needs. Team members are able to support enrollees by providing coordinated interventions in their various areas of expertise while shouldering the overall workload at the same time. Eliot will provide flexible, fluid, and coordinated services that meet the current needs of enrollees and to meet all of our contractor responsibilities in each Service Area. Our CP model is comprehensive and collaborative, with an intrinsic devotion to flexibility and quality care. Below is a brief summary of CP team members, senior managers, and clinical and medical leadership (*See Organizational Chart in Attachments*).

Title	Essential Responsibilities
Engagement Specialists (Recovery Coaches Incorporated)	Conduct outreach and engagement of newly assigned enrollees. Conduct face to face visits, phone calls, and use other technologies to engage with assigned enrollees. Explain benefits, purpose, design and process of services of the CP. Obtain participation form from assigned enrollees and assist in engagement with the CP team. Provide administrative support.
Care Coordinator	Coordinate all aspects of service delivery specific to the needs and preferences of the enrollee. Provide person-centered Comprehensive Assessment and person-centered treatment planning. Provide primary coordination and contact with the enrollee, PCP and Care Team. Utilize MI to support and assist enrollee's in achieving their goals. Utilize WHAM and PSWHIR to develop and support wellness goals
Care Coordinator (Peer Specialists and Recovery Coaches)	All essential responsibilities of Care Coordinator as above. Utilize Individualized Peer Supports and Recovery Coaching to support enrollees in achieving goals and advocacy.
Clinical Care Manager	Provide clinical supervision and support to assigned Care Coordinators and Engagement Specialists. Participate and provide supervision of the person centered comprehensive assessment and treatment planning process, provide approval. Support Care Coordinators and provide collaboration to enrollees and members of the Care Team in achieving enrollee's goals. Ensure coordination with PCPs, Care Teams, and active engagement with enrollees under assigned Care Coordinator. Ensure communication, collaboration and coordination ACOs and MCOs.
Nurse	Provide and ensure medication reconciliation. Assist and provide medical care coordination. Engage medical providers as a liaison for enrollees and assist enrollee's in engagement with medical providers, recommendations, and other types of health/medical supports. Provide education and consultation to enrollees and CP team members regarding medical, health

	and medication related topics. Perform medical tasks as needed and direct interventions to enrollees related to their treatment plan. Provide motivational interviewing, wellness coaching, and care management.
CP Director	Oversee all administrative functions of the CP and is responsible for the overall oversight of services for enrollees. Provide leadership and supervision to Clinical Care Managers and Nurses. Monitor service delivery and utilization of services. Provide clinical consultation to the Care Teams and coordinate as needed with ACOs and MCOs.
Director of Clinical Consultation	Manage and oversee implementation of clinical initiatives, evidence based practices, and motivational interviewing coaches. Supervise field clinicians providing evidence based practices, risk management, and clinical assessment.
Director of Peer and Recovery Services	Provide support and supervision to Peers and Recovery Coaches. Provide coaching and training in IPS, PSWHIR and WHAM. Provide supervision to Peers and Recovery Coaches. Assist in ensuring CP's are recovery oriented and focused on person centered planning.
Medical Director	Provide leadership and oversight of all behavioral health, medical, and clinical services. Provide direct supervision over all prescribing staff at Eliot. Provide medical consultation to CP teams. Provide guidance and supervision to Nurses on CP teams. Act as a liaison when needed to ACOs, MCOs, PCPs, and other medical professionals.

2. Sample Staffing Model

Below is a sample staffing model for an Eliot CP team based on serving 1,000 actively engaged enrollees. In Service Areas where the number of the estimated population of enrollees is less than or more than 1,000, Eliot will proportionally adjust the number of team members:

Title	Caseload/Supervision	Total FTE Per 1000 Enrollees
Engagement Specialists	Up to 70 newly assigned enrollees per month.	3
Care Coordinators (Either with lived exp. or without)	Average 60-80 actively engaged enrollees.	16
Clinical Care Manager	Will provide direct clinical supervision, administrative support, and management to 4 Coordinators and 3 Engagement Specialists	4
Nurse	Support 4 Care Coordinators and 1 Clinical Care Manager	4
Community Partner Director	Provide Supervision to 4 Clinical Care Managers and 4 Nurses.	1

3. Recruitment Plan and Job Descriptions

Eliot has focused on workforce development for several years, honing recruitment techniques, training capacity, retention strategies, and implemented an expanded internship program. We have had a Workforce Development Department for over the past 15 years including a

recruitment team dedicated to recruiting highly qualified candidates. Our internal resources have made a significant impact on Eliot's vacancy rate, as well as our proven ability to develop and manage new programs, services, and initiatives. Currently, Eliot's vacancy rate is less than 5%, far below the industry standard. In conjunction with these resources the Behavioral Health Division employs a dedicated Workforce Coordinator who works collaboratively with Eliot's Workforce Development, Human Resources and Quality Management Departments to facilitate and streamline hiring and recruitment of vacant positions as well as staff training. This position is utilized to coordinate, track, interview and screen potential applicants, track vacancies, participate in recruitment efforts as well as conduct and facilitate trainings. Mobilizing these resources, as well as other managerial staff, clinical staff, and staff who currently work at Eliot, we are able to ensure the hiring and deployment of qualified staff who can be utilized upon inception of the contract. We anticipate that upon award, we will begin our recruitment efforts both internally, through social media, job fairs, and individualized recruitment to highly qualified individuals outside of Eliot. It is anticipated that a number of our clinical staff, working within our continuum, will transfer into clinical positions, peer positions, and coordinator positions within our CP teams. We have also identified a number of employees who will be able to be redeployed and reclassified as a result of the new service model. Below is our proposed timeline for recruitment of staffing positions:

Activity	Start Date	Anticipated Completion Date
Identify current staff, resources, and restructuring to fully incorporate CP model into Eliot continuum	Current	Upon Award
Identify and redeploy internal administrative, clinical staff and coordinators within Eliot to work on the CP teams	Upon announcement/award of CP team contracts	October 2017
Redesign Eliot website, social media tools, and recruitment tools to include CP teams to begin recruitment outside of Eliot	Upon announcement/award of CP team contracts	Within 2 weeks of award
Recruit/hire CP Directors either within Eliot or from outside of Eliot	Upon announcement/award of CP team contracts	Hire 2 CP Directors April/ May 2018
Recruit/hire all CP Clinical Care Manager	Upon announcement/award of CP team contracts	Hire 3 CP Clinical Care Managers 2/15/18
Recruit/hire all CP Nurses	Upon announcement/award of CP team contracts	Hire 2 CP Nurses 2/15/2018
Recruit/hire all Care Coordinators(with lived experience or without)	Upon announcement/award of CP team contracts	Hire 15 Clinical Care Coordinators no later than 3/1/2018
Recruit/hire all Engagement Specialists	Upon announcement/award of CP team contracts	Hire 2 Engagement Specialists no later than 3/1/2018

Please see *Job Descriptions in Attachments.*

4. Cultural and Linguistic Competency

Eliot is dedicated to ensuring that CP services are culturally competent and address the cultural and linguistic needs of the population we service in every CP community. We are committed to hiring and retaining staff that will provide culturally and linguistically competent supports that reflect the population we serve. Eliot is constantly assessing cultural and linguistic needs of our populations we serve and developing recruitment strategies designed to hire staff with these expertise. As noted earlier, Eliot employs over 200 staff who speak 20 different languages, all of which reflect the communities we currently provide services within and those in which we anticipate operating CPs. Eliot's commitment to the employment and retention of culturally competent staff members, is demonstrated by offering a 6% salary differential for qualified applicants who possess bi-lingual capabilities. Over the years we have found a number of productive avenues to recruit staff such as cultural centers, social media outlets, and our own staff. When internal resources are not available, Eliot utilizes interpreter services to ensure that we are able to communicate with our members in their primary language. As Eliot staff and consumers have become increasingly diverse, so have our services. In an effort to further support an atmosphere that embraces cultural diversity, Eliot has established an Inclusion and Diversity Council comprised of a cross section of staff. This Council was established to build upon our foundation and is meant to communicate our ongoing commitment to being a culturally competent, inclusive and diverse organization where everyone feels welcomed and respected regardless of any real or perceived difference. This Council has been instrumental in not only supporting our diverse staff members, the populations we serve, but also in assisting the organization in recruitment efforts.

5. Training and Orientation Plan

Eliot's week long New Staff Training is held at our primary Training Center in Lexington. This training is completed before beginning work in any of our service elements. Pre-service training is the foundation upon which all other training is built. The primary purpose is to expose the staff members to core competency training, service elements, service continuum, and population needs. Staff members receive training on the importance of a strengths based approach to treatment and how to manage behavioral risk. New Staff Training promotes a quality approach to service delivery. New staff members on the CP teams will complete an additional 40 hours of comprehensive orientation training in Complex Care Management and Coordination with their respective team through our online training and educational suite, eLAN. Our Workforce Development Department and the Director of Clinical Consultation are currently developing this 40 hour curriculum which will be based on the University of Vermont's research and outcomes from the Patient-Centered Outcomes Research Institute (PCORI).[xi] The PCORI research and outcomes is not only at the forefront of person centered care

management, but there is clear evidence on strategies and interventions that work for the SPMI population. Each CP team will also include as part of the team orientation a review of available community resources, introductions to key staff and programs, modeling of clinical interventions and engagement, and approach to service delivery. All new staff receive 160 hours of training in their first year of employment at Eliot. A 40 hour course on Leadership is offered on a quarterly basis. It is designed to provide the participants with the theory and concepts of leadership that they can apply directly to the duties and responsibilities at their programs. Eliot has developed a partnership with Boston College whereby staff who complete Eliot trainings in established clinical domain areas can receive an Advanced Clinical Certificate from BC. These trainings include DBT, CBT, Harm Reduction, Recovery Oriented Practice, Illness Management and Recovery, Person Centered Planning, Motivational Interviewing (I-III) and CBT for PTSD (I and II). Eliot has devoted considerable resources to ensuring clinical staff have adequate training and maintain their licensure. Clinical staff are encouraged to attend sponsored continuing educational opportunities to increase skill sets and maintain licensure. Eliot also dedicates considerable resources annually to bring in outside clinical experts to provide specialized skills training.

6. Staff Retention Strategy

It is our belief that staff members that who feel empowered, valued and respected take pride in their work, are more productive, provide quality services and are retained by the organization. This is a fundamental practice of our change management philosophy based on LEAN and continuous improvement. Eliot is dedicated to ensuring a work environment and organizational culture that communicates with, listens to and recognizes the accomplishments of its staff. The agency employs a comprehensive strategy for employee retention which includes a number of communication vehicles that keep staff up to date with agency news. We obtain feedback from staff through annual satisfaction surveys, forums, committees and program visits from executive staff. Our staff are included in making service and agency decisions both to be empowered and to ensure informed decision making. We also have a progressive bonus and incentive system for recruitment, longevity, referring friends/family to work at Eliot, and performance incentives/bonuses. Eliot offers a robust training calendar as well as tuition reimbursement program. Based on data gathered in the HRIS system in calendar year 2016, managers average tenure was 5.87 years, direct care staff 3.43 years, and clinicians 4.37 years. These figures are either equal to or greater than industry standards. A deliberate focus on successful management practices provides staff confidence and a greater range of knowledge. Managers strive to teach, and train staff in all facets of their respective positions. The benefit of successive management is staff has a broader range of knowledge, stronger pool of internal candidates to choose from, career ladders, and more effective service delivery.

F. Implementation Plan and Timeline

Eliot's Implementation Plan and Timeline is attached.

G. Budget Report and Budget Narrative

Eliot's Budget Report and Narrative is attached.

H. Sustainability

Eliot is fully committed to the successful implementation of our CP programs, achieving outcomes measures, and the sustainability of the service. Our goal in providing CP services is to support and coordinate services across the existing continuum of care and the newly created ACO continuum for enrollees with severe mental illnesses and those with substance use disorders. We are committed to partnering with EOHHS, ACOs, MCOs, and all of our partners to achieve full integration of care for enrollees for all of their medical, behavioral health, and life needs. Our system of care, services, and the technologies we are planning to implement will not only achieve this integration but will ensure the highest quality of care and improve the wellness of the enrollees we serve.

The partners and technologies we have chosen to build our CP infrastructure and our CP capacity with have demonstrated successful implementation and sustainability in other projects and development of integration of systems. Eliot's utilization of the infrastructure DSRIP funds will be maximized over the preparation budget period and through the five budget periods to ensure sustainability without the need for continued development and funding. Our conversations with our partners, and our vision, are to utilize the higher levels of funding from the initial preparation funds and sunset those costs throughout the DSRIP budget periods. Many of our investments will be fully paid for by the end of the first budget period, while others will have expected maintenance fees that Eliot will absorb both within our internal operations budget and administrative overhead budget.

As noted in our Budget Report and Budget Narrative, Eliot intends to partner with eHana to develop a statewide CP Care Management platform, and these dollars represent the largest percentage our technology investment. The costs related to the related to our investment in the eHana system fully sunset by the end of budget period five. By the end of this period, our investment will include all: of the programmatic interfaces and requirements; the analytics needed for reporting; full integration across ACO and MCO partners and providers; and include any Eliot specific enhancements or changes to the eHana system. We expect to include a nominal software maintenance fee beyond budget period 5, and as we have worked with eHana on the development and implementation of our EHR, we have firsthand knowledge that this is a realistic expectation and fully sustainable through our sound organizational financial practices. Our investments into other technologies including telehealth, mobile technology, hardware, and phone systems and monitoring, will also wind-down by the end of budget period five. We anticipate needing to replace some hardware overtime, continue with maintenance fees of software, and invest in some upgrades of these systems. However, our experience in start-ups and other investments in projects demonstrates our clear ability to not only achieve

implementation but also achieve sustainability of robust cutting edge technologies in behavioral health.

Our investments in workforce development projects will also be fully operationalized and paid for by the end of budget period five. As noted, we expect to invest in developing both in person and online training within our current training programs, including our web based ELAN system. This will include costs associated with implementing the 40 hour Complex Care Management training based on the University of Vermont's research and outcomes from the Patient-Centered Outcomes Research Institute (PCORI). Additionally, we anticipate added staff training investments for PSWHR during the preparation budget and first budget period. We have implemented similar training plans for our CBFS programming, Motivational Interviewing, and clinical trainings such as CBT, DBT, Cognitive Restructuring, and Trauma Informed Care. By utilizing the DSRIP funding early to invest in the development of internal expertise and training ability, we will ensure sustainability of our workforce development within the CP programs beyond budget period five.

Eliot expects that investments made in business start-up and operational infrastructure will be fully absorbed both within the CP operational budgets and Eliot's administrative overhead budget by the end of year five. These investments include LEAN system change resources, staffing start-up, a dedicated Project Manager, and nominal operational changes and supports.

I. Quality Management and Performance Monitoring

Quality Management (QM) practices are a focal point at Eliot in guiding service delivery, ensuring person centered planning and developing sound management decisions. Eliot takes great pride in establishing high standards of care and continuously reviewing our operations to identify opportunities to enhance service delivery. Eliot's QM systems are well developed, make use of current technology, utilize consistent data, are outcome driven and focus on continuous quality improvement and our change management philosophy of LEAN. Eliot's QM department provides the infrastructure and institutional knowledge required to ensure that Eliot is achieving its performance improvement goals and is providing quality data to inform decisions and meet the requests of our funding stakeholders. We anticipate that our QM department will spearhead the effort to develop new data collection, reports, and statistical analysis to assess the efficacy and ensure performance improvement of the new CP model. Eliot will ensure our QM plan is submitted to EOHHS no less than annually. Our QM team works in harmony with our IT department to deliver meaningful data analysis, outcomes reports, and trend analysis.

1. Description of Quality Improvement Program

Eliot's quality improvement plan for our CP services will be based on our LEAN philosophy and tools for continuous improvement. Our first step will be to provide our CP staff members specific goals as a means to give them a purpose to achieve. By setting goals for the teams at the onset of services we will provide the teams with a sense of ownership over the CP service model and build buy-in to process improvement. In being clear on the CP's goals and purpose, we can then focus on creating and improving the process to achieve these goals. We anticipate that our initial goals will focus on the overall CP process:

Goal	Purpose
Contact newly assigned enrollees within 72 hours	Immediate engagement of population in significant need of services
Meet newly assigned enrollees face-to-face within 7 days	Demonstrate the flexibility of the service and the utility to the assigned enrollee
Complete comprehensive assessment for every engaged enrollee within 90 days	Ensure an understanding of the enrollee and their needs and desires for service
Complete PCP treatment plan for every engaged enrollee within 90 days	Ensure the enrollee's goals for health and wellness improvement are driving force and motivation for treatment. Ensure full CARE Team is engaged
Maintain 1 contact with engaged enrollees every 7 days	Demonstrate compassion and support to the enrollee and sustained effort on the treatment plan
CP staff present at discharge/care transition planning meetings for engage enrollee	Ensure a well facilitated and feasible plan is in place to support the enrollee in improving their wellness in the community
CP staff meet with engaged enrollee face-to-face 3 days post discharge from a facility/service	Ensure the discharge/care transition plan is supported, effective, and assess for other services needed

Nurse provided medication reconciliation post inpatient stay	Ensure medication changes are correct and will be maintained in the community
CP staff facilitating mental health practitioner appointment/follow up within 7 days post acute hospitalization	Ensure there is mental health and community support to continue to maintain the enrollee's mental health in the community rather than in an inpatient setting

Once we have set goals, given the CP teams' purpose, we can then use Visual Stream Mapping (VSM) to map out the CP process and the team members responsible for each goal above. VSM allows us to engage team members in assessing both the processes needed to achieve goals but also the resources needed to achieve the. While VSM typically utilized to improve a process or meet a new challenge, we have found that it is extremely useful in planning and mapping before a new program and service start. Once we have a baseline VSM, we will then work with our teams over time to continue to use VSM to improve each process, move resources, and create efficiencies to achieve each goal.

Another fundamental approach we utilize within our LEAN framework is Plan-Do-Check-Act (PDCA). We have found that combining VSM and PDCA are keys in engaging staff members with our QM to make improvements to a service, a process, and ultimately in achieving a goal. We envision that within the Eliot CP system, we will use PDCA to make continuous improvements in conjunction based on VSM. Our PDCA method will focus on truly understanding a problem or goal we are trying to address, making sure we understand the barriers to the goal, and that our plan addresses it. We will then implement action steps (the DO) that we can measure/check to ensure we have addressed our original goal or problem. The Act in PDCA is the final step in creating a standardized system or protocol that is based on the planning, doing, and checking already completed. We will document these PDCA continuous improvements by updating our protocols and by completing VSMs with CP teams on the process improvements and changes. The LEAN tools of VSM and PDCA allow for rapid changes and improvement in achieving goals, which will be paramount in the CP goals we have set as well as in ensuring our workforce in purposefully engage in the CP work.

In conjunction with our QM team facilitating LEAN with our CP teams, QM will utilize our EHR, data systems, and analytics to track services and produce meaningful reporting to ensure continuous feedback to the CP teams as a means to quality improvement. This data is analyzed by QM staff to control for such variables as diagnoses, team members, specific interventions/service provided, and demographics. Our QM utilizes Statistical Package for the Social Sciences (SPSS) to run regression analysis as well as correlation analysis. Eliot anticipates the QM team will collect and analyze the following data elements beyond the required data/outcomes to ensure continuous quality improvement within our CP programs: Quality of Life Scale (QOL);[xii]Tracking reporting on medical diagnoses and comorbid conditions including COPD, Diabetes; Tracking of medical hospitalizations, psychiatric hospitalizations, emergency

room visits, and other facility/institutional placements; Tracking of coordination of AOD treatments, placements, and services; Tracking of care coordination activities related to warm hand offs.

2. Planned QM Initiatives

As noted, our first QM initiative within the newly created CP model will be to implement LEAN to ensure a culture of problem solving and continuous improvement. Our LEAN process with the CPs will begin prior to implementation and will be a meaningful QM and CP team approach towards standardization, goal achievement, and improving engagement and outcomes for enrollees. Beyond our planned initiative focused on LEAN, Eliot has committed to implementing the expanded version of the Quality of Life Scale (QOL). The tool is easy to understand, user friendly and only takes a short amount of time to administer. We plan to administer the QOL at the beginning on CP services and on a quarterly basis. Research demonstrates the average total score for healthy populations is about 90 with varying lower indication for a group with chronic illness.[xiii] Eliot seeks to improve enrollees' quality of life to be that of at least 75% of the healthy population within their first full year of CP service. Eliot also aims to see individual progress with enrollees scores rise by 5 points within their first full year of CP services. The QOL Scale also provides opportunities to leverage the identified subsets that exist within the tool to identify specific need areas, use to track the efficacy of specific interventions. These subsets include: Material and physical wellbeing; Relationships with other people; Social, community, and civic activities; Personal development and fulfillment; Recreation; Independence. We envision that tracking these subsets will lead to other QM initiatives, along with leveraging other collected data, within the CP model to improve Quality of Life and Chronic Disease Management.

3. Quality Management Committee

It is imperative that the QM team be integrated with consumers and family members to ensure that any QM plan or activities is person centered. Consumer and family involvement is vital to help steer the QM team in the improvement process. To this end, Eliot has a Quality Management Committee that reports directly to a subcommittee within our Board of Directors. The Committee includes: QM team, consumers, family members, stakeholders from the community, Eliot's Compliance Officer, Eliot's Medical Director and several clinicians and administrative staff members throughout each division and service element. The committee participates in the development of QM initiatives and review QM data, outcomes and reports. The committee focuses on assisting QM staff in achieving QM goals and initiatives throughout the organization and that the organization is in support of each division and service QM plans. Once awarded CP programs, Eliot will ensure CP participation within the committee.

J. Coordination with ACOs and MCOs

1. Communication and Value to ACOs and MCOs

As a large behavioral health provider, Eliot has a vast amount of experience and knowledge engaging and serving SMI and SUD populations. Understanding this population we are able to successfully implement an integrated care management program that successfully addresses the complex needs of this specialized population that translated to lowering health care costs while improving care and quality of life for the people we serve. Eliot has begun preparing materials that can be utilized for presentations and information sessions with the MCOs and ACOs. This material will outline the need for and advantages of utilizing our behavioral health community partner program as well as the key components of the service. In addition to outlining the value of the program, Eliot will also highlight our specific expertise and experience with this population. Eliot is will also share current outcomes and results of our programs to further illustrate the importance of these services. We have had a long standing history of contracting, piloting and developing new programing with many of the MCOs. Our staff routinely confer with MBHP, Beacon and NHP related to our ESP, PACT, Clinic, CSP, and HFY contracts. Eliot also has a history of working collaboratively and coordinating care with many of the potential ACOs. Utilizing these relationships as a foundation for future partnerships, Eliot began meeting with potential ACOs and MCOs over the past year. To date, Eliot has had discussions with Cambridge Health Alliance, Wellforce, Partners Healthcare, Beacon and Lynn Community Health Center. It is anticipated that we will meet with the remaining ACOs and MCOs in the next month. These meetings have focused on sharing the expertise of each organization, identifying areas where our services currently intersect, vision and goals for coordinated service delivery, as well as methods and systems for communication. Many of these conversations have assisted both organizations in brainstorming key components for successful coordination of BH CP program with a strong emphasis on data/ information exchange and client assignment. Eliot has provided the ACOs and MCOs with its care management approach for the BH CP identifying the expertise of our organization. Using real life examples of current approaches and barriers to care the SMI and SUD population experience has been useful in this process.

2. Branding and Marketing

It is Eliot's intention to partner with the ACOs and MCOs developing a Memorandum of Understanding that clearly outlines our relationship. Through this process a marketing and branding plan will be established with the organizations. In addition, Eliot will create marketing materials and a campaign that will be used to educate primary care, medical and other

treatment providers as well as clients and families. We envision the marketing process will be multifaceted with the ACOs and MCOs as well as other community providers.

3. Strategy to Engage and Collaborate with Multiple ACOs and MCOs

Eliot has begun meeting with the ACOs and MCOs and will continue this process throughout the next several months. Eliot is interested in developing positive partnerships with all parties and identifying a pathway to integrated care. Utilizing the strategy previously outlined, Eliot will present information about Eliot and its vision for coordinated care. We will engage in discussions that outline potential barriers and concerns as well as shared vision for our partnership. For example, a common concern expressed during our ACO meetings is that the BH CP program will steer clients away from their current provider and into their own services. When speaking about this issue openly, all parties realize that this concern is universal to all potential ACOs, MCOs and BH CP programs. We believe that these discussions are important in the development of partnerships and throughout our relationship.

4. Strategy for Conflict Resolution

Developing systems for regular communication, process improvement and conflict management are important components of the MOU agreements with ACOs and MCOs. Over the years we have found that outlining clear lines of communication with designated points of contact along with regularly scheduled meetings and agendas can assist in proactively addressing areas of concerns for both parties. Transforming the Medicaid healthcare system and venturing into new territory will be challenging for all parties. Ensuring there are on-going discussions and work plans related to process improvement will aid in this process. We know that conflict is inevitable in any relationship. However, utilizing a respectful transparent process for negotiating resolutions to conflict, coupled with proactive communication can lead to lead to positive outcomes and improved services.

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[xii] http://www.tellusnaturals.com/documentos/qol.pdf

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Community Partner Program Budget Report

High point

Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Estimated Enrollees- Start of Period (All Enrollees)		2,740	2,740	4,135	5,555	7,225	
Estimated Enrollees - End of Period (All Enrollees)		2,740	4,135	5,555	7,225	8,720	
Estimated Enrollees - Monthly Average (excl CBFS enrollees)		2,151	3,513	5,013	6,691	8,520	
Estimated Enrollees - Monthly Average (CBFS enrollees only)		82	105	139	191	200	
Estimated Program Revenue (excl CBFS enrollees)		$ 2,710,260	$ 7,588,080	$ 10,828,080	$ 14,452,560	$ 18,403,200	$ 53,982,180
Estimated Program Revenue (CBFS enrollees only)		$ 143,500	$ 315,000	$ 417,000	$ 573,000	$ 600,000	$ 2,048,500
Total Estimated Program Revenue		**$ 2,853,760**	**$ 7,903,080**	**$ 11,245,080**	**$ 15,025,560**	**$ 19,003,200**	**$ 56,030,680**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -		$ -	$ -
Revenue for Operations		**$ 2,853,760**	**$ 7,903,080**	**$ 11,245,080**	**$ 15,025,560**	**$ 19,003,200**	**$ 56,030,680**

	Program Expenses		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
1	**Salary**		$ 70,898	$ 2,124,952	$ 5,497,400	$ 7,385,261	$ 9,605,493	$ 11,593,066	$ 36,277,070
2	**Fringe**		$ 16,955	$ 508,161	$ 1,314,648	$ 1,766,111	$ 2,297,057	$ 2,772,366	$ 8,675,298
	Total Personnel Costs		$ 87,853	$ 2,633,113	$ 6,812,048	$ 9,151,372	$ 11,902,550	$ 14,365,432	$ 44,952,368
3	**Training & Professional Development**		$ -	$ 22,377	$ 57,890	$ 77,770	$ 101,150	$ 122,080	$ 381,267
4	**Travel**		$ -	$ 90,785	$ 234,041	$ 314,413	$ 408,935	$ 493,552	$ 1,541,726
5	**Equipment**			$ -	$ -	$ -	$ -	$ -	$ -
6	**Supplies**		$ -	$ 18,381	$ 47,553	$ 63,883	$ 83,088	$ 100,280	$ 313,185
7	**Contract Services** (consulting, professional)		$ -	$ 119,875	$ 310,125	$ 416,625	$ 541,875	$ 654,000	$ 2,042,500
8	**Software licensing**		$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	**Telecommunications**			$ 38,360	$ 99,240	$ 133,440	$ 173,520	$ 209,280	$ 653,840
10	**Occupancy** (rent, utilities, maintenance)		$ -	$ 84,568	$ 218,784	$ 293,916	$ 382,276	$ 461,376	$ 1,440,920
11	**Other**			$ 160,965	$ 426,843	$ 585,991	$ 770,121	$ 946,865	$ 2,890,785
	Total Direct Costs		$ 87,853	$ 3,168,424	$ 8,206,524	$ 11,037,410	$ 14,363,515	$ 17,352,865	$ 54,216,591
12	**Indirect Cost/Administrative Overhead**	12.0%	**$ 10,542**	**$ 380,211**	**$ 984,783**	**$ 1,324,489**	**$ 1,723,622**	**$ 2,082,344**	$ 6,505,991
	TOTAL EXPENSES		$ 98,396	$ 3,548,635	$ 9,191,307	$ 12,361,899	$ 16,087,137	$ 19,435,209	$ 60,722,582
	Surplus/Shortfall		*$ (98,396)*	*$ (694,875)*	*$ (1,288,227)*	*$ (1,116,819)*	*$ (1,061,577)*	*$ (432,009)*	*$ (4,691,902)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Program Manager	$ -	0	0.000000	$ -
Program Director	$ 80,000.00	1.37	0.230947	$ 2,109
Clinical Case Mgr	$ 55,000.00	5.48	0.230947	$ 5,801
Registered Nurse	$ 83,200.00	10.96	0.230947	$ 17,549
Care Coordinator-MA	$ 42,000.00	13.7	0.230947	$ 11,074
Care Coordinator - BA	$ 34,099.00	46.58	0.230947	$ 30,568
Admin/Billing	$ 48,000.00	4.11	0.230947	$ 3,797
Total Salary (Program Budget Line 1)		**82.20**		**$ 70,898.45**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 70,898.45	24%	$ 16,954.61
Total Fringe (Program Budget Line 2)			**$ 16,954.61**

Total Personnel*	**$ 87,853**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

Note: The above amounts represent one week's salary of each of the position. Funds for these salaries are allocated between Partners based on volume.

Program Director -Will oversee the program and be responsible for hiring, supervision, and training.
Clinical Care Manager (LICSW)-Each Clinical Care Manager will supervise 11 Care Coordinators. They will be responsible for reviewing and approving their supervisees' comprehensive assessments and treatment plans.
Clinical Care Manager (RN)-The RN will review all enrollees' medical information, compliance with prescriptions, medication reconciliations, and ensure MAP requirements are met.
Care Coordinator-MA -Will be responsible for providing care coordination to enrollees. These Masters' level staff will be responsible for high risk, complex enrollees. These individuals may have lived experience.
Care Coordinator - BA- Will be responsible for providing care coordination to enrollees. These individuals may have lived experience.
Admin. Assistant - Will be responsible for the day to day administrative tasks of the program.
Intake and Billing -Will be responsible for collecting demographic data, insurance information, and ensure that all services are accurately billed.

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Total Training and Professional Development (Program Budget Line 3)			

Provide a description of each Training and Professional Development line item included in the table above:

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
				$ -
				$ -
				$ -
				$ -

	A	B	C	D	E	F
93					$ -	
94					$ -	
95				**Total Mileage**		

	Travel Expense Description	Cost
98	Total Mileage	$ -
99	Parking and tolls	
100	Public transportation	
101	Enrollee travel	
102	**Total Travel**	**$** -
103	**(Program Budget Line 4)**	

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

Row 5 - Equipment

	Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost
125				
126				
127				
128				
129				
130				
131				
132			**Total Equipment (Program Budget Line 5)**	

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Total Supplies (Program Budget Line 6)			

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
Total Software Licensing (Program Budget Line 8)			

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost

	A	B	C	D	E	F
284						
285						
286				**Total Telecommunications**		
287				**(Program Budget Line 9)**		
288						
289						
290	***Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and***					
291	***how the costs were determined:***					
292						
293						
294						
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316						
317						
318						
319	**Row 10 - Occupancy**					
320	**Occupancy Expense**	**Total SqFt**	**Cost/SqFT**	**Cost**		
321	Rent			$ -		
322	Utilities			$ -		
323	Repair and Maintenance			$ -		
324				$ -		
325				$ -		
326			**Total Occupancy (Program Budget Line 10)**			
327						
328	***Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how***					
329	***the costs were determined:***					
330						
331						
332						

Row 11 - Other

Other Direct Expense Description	Cost
Total Other (Program Budget Line 11)	

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	12.00%	$ 10,542.37

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Total proposed costs during the preparation budget period are 87,183. The average administrative overhead rate of the affiliated partners is 12%.

	A	B	C	D	E	F
430						
431						
432						
433						

Community Partner Infrastructure Budget Report

High Point

Infrastructure Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
PMPM Infrastructure Rate		$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
Engaged Enrollees		2,740	2,740	4,135	5,555	7,225	
Estimated Infrastructure Funds		$ 1,918,000	$ 2,829,295	$ 2,555,016	$ 3,026,588	$ 3,405,387	**$ 13,734,286**
At- Risk Withhold Rate			25%	44%	63%	81%	
Withhold			$ 698,716	$ 1,114,716	$ 1,893,473	$ 2,775,189	**$ 6,482,095**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 1,918,000	$ 2,130,579	$ 1,440,300	$ 1,133,115	$ 630,198	**$ 7,702,191**

	Infrastructure Investment Projects		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
	Technology								
1	**IT Staffing including Fringe**		$ 41,303	$ 57,825	$ 99,128	$ 99,128	$ 99,128	$ 99,128	**$ 495,640**
2	**Development Adaptation of EHR and/or Care Management System**		$ 100,000	$ 370,000	$ -	$ -	$ -	$ -	**$ 470,000**
3	**Technology for Service Delivery**		$ 37,114	$ 37,114	$ 34,439	$ 37,323	$ 43,884	$ 39,294	**$ 229,167**
4	**Other Technology Expenses**		$ 5,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000	**$ 10,000**
	Total Technology		$ 183,417	$ 465,939	$ 134,567	$ 137,451	$ 144,012	$ 139,422	**$ 1,204,808**
	Workforce Development								
5	**Workforce Development staffing including Fringe**		$ 15,489	$ 36,140	$ 61,955	$ 61,955	$ 61,955	$ 61,955	**$ 299,449**
6	**Recruitment Expenses**		$ 12,478	$ 20,000	$ 20,000	$ 20,000	$ 20,000	$ 20,000	**$ 112,478**
7	**Training Expenses**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
8	**Retention Expenses**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Workforce Development		$ 27,967	$ 56,140	$ 81,955	$ 81,955	$ 81,955	$ 81,955	**$ 411,927**
	Business Start Up Costs								
9	**Office Equipment (PBP & BP1 only)**		$ -	$ 50,000.00					**$ 50,000**
10	**Office Furniture (PBP & BP1 only)**		$ 56,082	$ 26,392.00					**$ 82,474**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**		$ 98,396	$ 694,875	$ 1,288,227	$ 1,116,819			**$ 3,198,317**
	Total Business Start Up Costs		$ 154,478	$ 771,267	$ 1,288,227	$ 1,116,819			**$ 3,330,791**
	Operational Infrastructure								
12	**Operation Staffing including Fringe**		$ 46,466	$ 173,474	$ 297,384	$ 297,384	$ 297,384	$ 297,384	**$ 1,409,476**
13	**Other Operational Expenses**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Operational Infrastructure		$ 46,466	$ 173,474	$ 297,384	$ 297,384	$ 297,384	$ 297,384	**$ 1,409,476**
14	**Indirect Cost/Administrative Overhead Rate**	12.0%	$ 37,672	$ 92,633	$ 61,669	$ 62,015	$ 62,802	$ 62,251	**$ 379,042**
	TOTAL INVESTMENTS		**$ 450,000**	**$ 1,559,453**	**$ 1,863,802**	**$ 1,695,624**	**$ 586,153**	**$ 581,012**	**$ 6,736,044**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
IT Project Manager	$ 80,000.00	1	5	$ 33,333
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary			$ 33,333
	Fringe rate	23.9%	Total Fringe	$ 7,970
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 41,303**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

The IT Project Manager represents the value of one FTE and will be allocated to the affiliated partners based on projected FTE's. This position will supervise the development and implementation of the Care Coordination software system. Other duties will include supervision of the help desk and the IT technicians responsible for set-up of desktops.

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost

	A	B
33	The initial cost of development of the Care Coordination system.	$ 100,000.00
34		
35		
36		
37		
38		
39	**Total Development and Adaptation of EHR and Care Management System (Infrastructure Budget Line 2)**	

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Currently, the search for the Care Coordination system has been narrowed to a few companies. The estimated cost at this time is in the $100,000 range. This total amount is allocated to HPTC since it will be responsible for coordinating and implementation.

Row 3 - Technology for Service Delivery

	Description of Expense	Cost
60	Purchase of approximately 41 computers: $750 per desktop	$ 30,928.00
61	Set-up of approximately 41 computers; $150 per desktop	$ 6,185.55
62		

	A	B	C	D	E	F	G
63							
64							
65							
66	**Total Technology for Service Delivery**	**$ 37,113.55**					
67	**(Infrastructure Budget Line 3)**						
68							
69	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
70	***contract and how the costs were determined:***						
71							
72	***The cost was developed from the average price of a desktop computer. All staff will need a computer to complete their daily***						
73	***work.***						
74							
75	***Each computer that is purchased has to be set-up with the access to the care management system and other software that will***						
76	***be necessary for the staff members to complete daily work. The cost has been estimated at $150 per computer. 41 computers***						
77	***represent 50% of the total # of computers needed for the 82 FTEs to be hired to support the expected volume of enrollees in***						
78	***Year 1.***						
79							
80	***Funds are allocated between Partners based on volume.***						
81							
82							
83							
84							
85	**Row 4 - Other Technology Expenses**						
86	**Description of Expense**	**Cost**					
87	Develop a Website.	$ 5,000.00					
88							
89							
90							
91							
92							
93	**Total Other Technology Expenses**						
94	**(Infrastructure Budget Line 4)**						
95							

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

The selection of a website developer has been narrowed to two companies, and the cost of developing the website will be in the $5,000 range. The website will make information available on the Internet about the services that will be provided. This total amount is allocated to HPTC since it will be responsible for coordinating and implementation.

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
HR Recruiter	$ 50,000.00	1	3	$ 12,500
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	1		$ 12,500
	Fringe rate	23.9%	Total Fringe	$ 2,989
Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)				**$ 15,489**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

The HR Recruiter represents the value of one FTE and will be allocated to the Affiliated Partners based on projected FTEs. This position will be responsible for developing policies and procedures, recruiting and onboarding and developing training materials.

Row 6 - Recruitment Expenses

Description of Expense	Cost
Advertising related to recruitment of staff	$ 12,478.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

To fill the required positions, it will be necessary to use social media to post online job opportunities, in addition to using traditional print media, websites, job fairs etc. The estimated *cost to advertise in these venues is $12,478.
The breakdown is as follows:
ZipRecruiter - 11 Active Unlimited Ads x 6 months = $2,250
Indeed - 11 positions boosted at 125/month x 6 months = $8,250.00
Boston Globe - 2 half page ads at $875/ad = $1,750.00

Total Cost = $12,250.00

~~Total cost – $12, 250.00~~

**** based on current advertising costs, subject to change***

Funds are allocated between Partners based on volume.

Row 7 - Training Expenses

Description of Expense	Cost
Total Training Expenses (Infrastructure Budget Line 7)	

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Row 8 - Retention Expenses

Description of Expense	Cost
Total Retention Expenses (Infrastructure Budget Line 8)	

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Business Start Up Costs - Prep Budget Period

Row 9 - Office Equipment

Description of Expense	Cost

	A	B	C	D	E	F	G
227							
228							
229							
230							
231							
232							
233	**Total Office Equipment**						
234	**(Infrastructure Budget Line 9)**						
235							
236	***Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were***						
237	***determined:***						
238							
239							
240							
241							
242							
243							
244							
245							
246							
247							
248							
249							
250							
251							
252	**Row 10 - Office Furniture**						
253	Description of Expense	Cost					
254	Furniture for 68% of projected first year FTEs- 82.47 ($1,000 *56.08)	$ 56,082.00					
255							
256							
257							
258							

	A	B	C	D	E	F	G
259							
260	**Total Office Furniture**						
261	**(Infrastructure Budget Line 10)**						
262							
263	***Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were***						
264	***determined:***						
265							
266	***The cost of purchasing furniture for each staff is estimated at $1,000. The amount of $56,082 represents the purchase of***						
267	***approximately 56 furniture sets, which will include a desk, chair, guest chair and small file cabinet.***						
268	***Funds are allocated between Partners based on volume.***						
269							
270							
271							
272							
273							
274							
275							
276							
277							
278							
279	**Community Partner <u>Infrastructure</u> Budget Report - Operational Infrastructure - Prep Budget Period**						
280	**Row 12 - Operational Staffing including Fringe**						
281	**Position**	**Annual Salary**	**FTEs**	**# Months**	**Total**		
282	Program Manager	90,000.00	1.00	5.00	37,500.00		
283					-		
284					-		
285					-		
286					-		
287					-		
288					-		
289					-		
290		Total Salary	1.00		37,500.00		

	A	B	C	D	E	F	G
291		Fringe rate	0.24	Total Fringe	8,966.25		
292	**Total Program Staffing including Fringe**				**46,466.25**		
293	**(Infrastructure Budget Line 12)**						
294	***For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting***						
295	***the terms of the CP's contract:***						
296							
297	***The Program Manager represents the value of one FTE and will be allocated to the affiliated partners based on projected FTE's.***						
298	***The Program Manager would be responsible for overseeing the staff, evaluating the start-up of the program, as well as***						
299	***evaluating the ongoing operations.***						
300							
301							
302							
303							
304							
305							
306	**Row 13 - Other Operational Expenses**						
307	Description of Expense	Cost					
308							
309							
310							
311							
312							
313							
314	**Total Other Operational Expenses**						
315	**(Infrastructure Budget Line 13)**						
316							
317	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms***						
318	***of the CP's contract and how the costs were determined:***						
319							
320							
321							
322							
323							

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**12.00%**	**$ 37,671.96**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Total proposed costs during the preparation budget period are $313,933. The average administrative overhead rate of the Affiliated Partners is 12%.

	A	B	C	D	E	F	G
354							
355							
356							
357							
358							
359							
360							
361							

Community Partner Infrastructure Allocation Worksheet

	Insert Contractor Name Here						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 1,918,000	$ 2,130,579	$ 1,440,300	$ 1,133,115	$ 630,198	$ 7,702,191
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
High Point Treatment Center	$ 157,660	$ 312,893	$ 90,366	$ 92,303	$ 96,709	$ 93,626	$ 843,557
Child and Family Services	$ 11,448	$ 68,020	$ 19,645	$ 20,066	$ 21,024	$ 20,353	$ 160,556
Bay State Community Services	$ 5,724	$ 34,010	$ 9,822	$ 10,033	$ 10,512	$ 10,177	$ 80,278
BAMSI (Brockton Area Multi-Services, Inc.	$ 5,008	$ 29,759	$ 8,595	$ 8,779	$ 9,198	$ 8,905	$ 70,243
Steppingstone Incorporated	$ 2,146	$ 12,754	$ 3,683	$ 3,762	$ 3,942	$ 3,816	$ 30,104
Duffy Health Center	$ 1,431	$ 8,503	$ 2,456	$ 2,508	$ 2,628	$ 2,544	$ 20,070
Total Technology	$ 183,417	$ 465,939	$ 134,567	$ 137,451	$ 144,012	$ 139,422	$ 1,204,808
Workforce Development							
High Point Treatment Center	$ 18,781	$ 37,700	$ 55,035	$ 55,035	$ 55,035	$ 55,035	$ 276,622
Child and Family Services	$ 4,083	$ 8,196	$ 11,964	$ 11,964	$ 11,964	$ 11,964	$ 60,135
Bay State Community Services	$ 2,041	$ 4,098	$ 5,982	$ 5,982	$ 5,982	$ 5,982	$ 30,068
BAMSI (Brockton Area Multi-Services, Inc.	$ 1,786	$ 3,586	$ 5,234	$ 5,234	$ 5,234	$ 5,234	$ 26,309
Steppingstone Incorporated	$ 766	$ 1,537	$ 2,243	$ 2,243	$ 2,243	$ 2,243	$ 11,275
Duffy Health Center	$ 510	$ 1,024	$ 1,496	$ 1,496	$ 1,496	$ 1,496	$ 7,517
Total Workforce Development	$ 27,967	$ 56,140	$ 81,955	$ 81,955	$ 81,955	$ 81,955	$ 411,927
Business Start Up Costs							
High Point Treatment Center	$ 103,737	$ 517,931	$ 865,087	$ 749,981	$ -	$ -	$ 2,236,736
Child and Family Services	$ 22,552	$ 112,594	$ 188,062	$ 163,039	$ -	$ -	$ 486,247
Bay State Community Services	$ 11,276	$ 56,297	$ 94,031	$ 81,520	$ -	$ -	$ 243,123
BAMSI (Brockton Area Multi-Services, Inc.	$ 9,866	$ 49,260	$ 82,277	$ 71,330	$ -	$ -	$ 212,733
Steppingstone Incorporated	$ 4,228	$ 21,111	$ 35,262	$ 30,570	$ -	$ -	$ 91,171
Duffy Health Center	$ 2,819	$ 14,074	$ 23,508	$ 20,380	$ -	$ -	$ 60,781
Business Start Up Costs	$ 154,478	$ 771,267	$ 1,288,227	$ 1,116,819	$ -	$ -	$ 3,330,791
Operational Infrastructure							
High Point Treatment Center	$ 31,203	$ 116,493	$ 199,703	$ 199,703	$ 199,703	$ 199,703	$ 946,509
Child and Family Services	$ 6,783	$ 25,325	$ 43,414	$ 43,414	$ 43,414	$ 43,414	$ 205,763
Bay State Community Services	$ 3,392	$ 12,662	$ 21,707	$ 21,707	$ 21,707	$ 21,707	$ 102,881
BAMSI (Brockton Area Multi-Services, Inc.	$ 2,968	$ 11,080	$ 18,994	$ 18,994	$ 18,994	$ 18,994	$ 90,021
Steppingstone Incorporated	$ 1,272	$ 4,748	$ 8,140	$ 8,140	$ 8,140	$ 8,140	$ 38,581
Duffy Health Center	$ 848	$ 3,166	$ 5,427	$ 5,427	$ 5,427	$ 5,427	$ 25,720
Operational Infrastructure	$ 46,466	$ 173,474	$ 297,384	$ 297,384	$ 297,384	$ 297,384	$ 1,409,476
TOTAL INVESTMENTS	$ 412,328	$ 1,466,820	$ 1,802,133	$ 1,633,609	$ 523,351	$ 518,761	$ 6,357,002

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Development and adaptation of EHR/care management system	Purchase and implement care manager system to be used for scope of project and care coordination between partners	08/01/17	03/01/18	Conclude workflow set-up in care manager platform and begin testing/training on system. Recommend revising to be more specific. Across how sites will you test?	Please add evidence						
Technology	Technology for service delivery	Purchase and deploy equipment needed to support the care manager product	03/01/18	05/31/18	Setting up of new equipment. Need to be more specific	Please add evidence						
Technology												
Technology												
Workforce Development	Workforce Development Staffing, including Fringe	Advertise for the Program Director	11/17/17	01/01/18	Hire the Program Director	Please add evidence						
Workforce Development	Workforce Development Staffing including Fringe	Advertise for the Human Resources position	11/17/17	01/01/18	Hire the Human Resources position	Please add evidence						
Workforce Development	Recruitment Expenses	Advertise for all positions	01/01/18	03/31/18	All positions posted and resumes received. Please be more specific	Please add evidence						
Workforce Development												
Business Start Up Costs	Office Furniture	Purchase furniture	01/01/18	03/31/18	All furniture ordered for delivery	Please add evidence						
Business Start Up Costs												
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Operation Staffing, including Fringe	Hire Program Manager	11/01/17	01/01/18	Program Manager employed	Please add evidence						
Operational Infrastructure	Technology for Service Delivery	Develop Website	11/01/17	03/31/18	Website live	Please add evidence						
Operational Infrastructure												
Operational Infrastructure												

BH Community Partner - Staffing Model

Insert Contractor Name Here

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	2740	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	1.37	*Total management oversight of BH CP*
3	Medical Director		*Included in contracted services*
4	RNs		
5	Clinical Care Managers (RN)	10.96	*RN*
6	Clinical Care Managers (LPHA)	5.48	*LICSW*
7	Supervisors/Team Leaders		*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff		*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	60.28	*Care Coordinators*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)		*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists		
12	Administrative Support	4.11	
13	Program Manager	0.274	*The Program Manager overesees more than the BH CP Program. An example of this position would be the VP of Adult Services. The UFR title of the Program Manager is Line 101 and the UFR title of the Program Director is Line 102*
14			
	Total FTE	82.474	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	250	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	11	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff: The Clinical Care Managers (5.48 FTE's) will provide direct supervision to the Care Coordinators.

Section 7.3 A. Executive Summary

Section 7.3 A. Executive Summary (2 pages)

1. The Coordinated Care Network (CCN) is comprised of High Point Treatment Center as the lead agency with 5 Affiliated Partners: Child & Family Services, Duffy Health Center, Steppingstone, Brockton Area Multi Services, Inc., and Bay State Community Services. In addition, we have included 2 Material Subcontractors: Community Health Center of Cape Cod and Brockton Neighborhood Health Center.

Careful thought and consideration were given to which partners would be included in the CCN. In order to be successful and build a 5-year business plan, we needed to partner with strong, dedicated, and quality organizations. Our commitment is to offer the state a Network where all partners are fully engaged, understand the MassHealth population, have proven strengths-based, high quality services, and demonstrates unwavering support to all tenets of DSRIP restructuring.

The DSRIP restructuring comes with both challenges and opportunities. We have identified the following as part of our 5-year work plan. First, we will need to strengthen our technological infrastructure in order to deliver services that our Enrollees deserve. CCN has taken a two-prong approach to meet this goal. We are proposing to use the strength of the system being built by the state, coupled with recommendations from the BHCP system throughout the Commonwealth to develop one robust common care management platform. This unified system will enable Enrollees to move seamlessly among their Community Partners and allow all of us to capitalize on combined financial and technological resources to develop a superior care management system for all Enrollees. CCN has developed a Network Operations Committee that is tasked with developing an infrastructure where our Affiliated Partners and Material Subcontractors will have the ability to efficiently exchange EMR data across the CCN Network, while also readily communicating with the ACOs/MCOs, and EOHHS. We believe this shared technology expertise within our affiliated members will afford a much smoother transmission of data among all organizations involved in the Enrollees' care.

Second, we recognize that workforce is a challenge for all of us throughout the state. There are simply not enough people choosing human services as a profession. The strength of our Network with over 5,000 employees in 200 locations allows us to collectively educate, advocate, and mentor anyone interested in choosing human service as a profession. As part of our 5-year plan, we will reach into our communities, high schools, colleges, and universities to educate students about career opportunities. We will share with them firsthand the experience of a deep satisfaction knowing you are making a difference in the lives of others as a human services worker. CNN will expand all training and internship opportunities to ensure we reach those interested in giving back to their communities.

2. CCN intends to support the following number of Assigned and Engaged Enrollees:

Year One	2,740
Year Two	4,135
Year Three	5,555
Year Four	7,225
Year Five	8,720

3. CCN is bidding on these service areas: Quincy, Attleboro, Barnstable, Brockton, Fall River, Falmouth, New Bedford, Orleans, Plymouth, Taunton, and Wareham.

4. This is an overview of CCN's plan to operationalize the CP program and implementation timeframes. The complete response is elaborated upon in Question 7.3F.
During the early part of the budget preparation period, Aug. 2017-Feb. 2018, attention will be focused on purchase and implementation of the care management software, identifying members for the CCN committees, setting committee meeting schedules, developing staff recruitment plans, and identifying office/meeting space. In addition, the program manager will begin working on the project, and policies and procedures will begin to be developed. During Jan.-May 2018, the latter half of the budget preparation period, the website will be configured, contractual agreements with ACOs/MCOs executed, staff training curriculum developed, care management tool configuration and testing completed; budget report and narrative completed for EOHHS approval. First and second interviews will be conducted; computers, tablets, and telephone configurations will be completed; and identified staff will be working mid-May 2018.

Year 1 (June 1-Dec. 31, 2018): Outreach and intake efforts, qualifying activities begin; EOHHS, ACOs/MCOs notified monthly of capacity to accept new referrals; info. on Consumer Advisory Board participation distributed to Enrollees. Monthly member status reports completed, and feedback sessions held with the care management software vendor to provide input on software enhancements. From Oct.-Dec., additional staff will be recruited; supplies ordered as appropriate, & Quality Improvement Plan developed, incorporating Enrollee feedback from engagement survey. Annual Report completed. All committees meet monthly and as needed, with Consumer Advisory Board meeting quarterly.

Year 2 (Jan. 1-Dec. 31, 2019): Outreach & intake efforts continue, renew contractual agreements with ACOs/MCOs, staff refresher trainings ongoing, EOHHS, ACOs/MCOs notified monthly of capacity to accept new referrals, and semi-Annual Report submitted to EOHHS; Quality Improvement Plan developed, incorporating Enrollee feedback from engagement survey. Supplies ordered as needed. Committees meet monthly & as needed; Consumer Advisory Board meets quarterly.

Year 3 (Jan. 1-Dec. 31, 2020): Outreach and intake efforts continue, renew contractual agreements with ACOs/MCOs, staff refresher trainings ongoing, EOHHS, ACOs/MCOs notified monthly of capacity to accept new referrals, and semi-Annual Report submitted to EOHHS by mid-summer. Committees meet monthly and as needed; Consumer Advisory Board meets quarterly. Quality Improvement Plan developed, incorporating Enrollee feedback from engagement survey. Supplies ordered as needed basis.

Year 4 (Jan. 1-Dec. 31, 2021): Outreach and intake efforts continue, renew contractual agreements with ACOs/MCOs, staff refresher trainings ongoing, EOHHS, ACOs/MCOs notified monthly of capacity to accept new referrals, and semi-Annual Report submitted to EOHHS by mid-summer. Committees meet monthly and as needed; Consumer Advisory Board meets quarterly. Quality Improvement Plan developed, incorporating Enrollee survey feedback. Supplies ordered as needed basis.

Year 5 (Jan. 1-Dec. 31, 2022): Outreach and intake efforts continue, qualifying activities continue; submit record of all qualifying activities, budget report and narrative submitted for approval. Committees meet monthly and as needed; Consumer Advisory Board meets quarterly.

Section 7.3. B. Supporting Populations and Community Engagement

Section 7.3. B. Supporting Populations and Community Engagement (2 pages)

B1. The Coordinated Care Network (CCN) maintains many diverse community connections and collaborations within each service area. In each area, these include state and federal agencies, CBHI systems of care, courts, school systems, shelters, police departments, community health and behavioral health centers, CBFS, CSP providers, Emergency Services programs, Long-term Support Services, and hospitals. In addition to these foundational connections, CCN has developed additional area-specific relationships. In order to include the business community, the CCN are members of several Chambers of Commerce and Rotaries, including Brockton, Middleboro, Hyannis, New Bedford, Plymouth, Taunton, and Quincy. We commit to fostering current relationships and continuing to grow new collaborations within our service areas to deliver the required CP supports. Our collective relationships with state and federal agencies include DMH, DCF, DPH, DYS, DTA, DDS, SSA, VA, OCC and MRC. All of the CCN partners work with peer-led organizations, including Learn to Cope, Parent Information Network, Parent Advocacy League, Recovery Centers and Recovery Learning Communities. Collectively, we operate at 200 locations throughout the service areas we propose to serve, providing a full continuum of behavioral health, SUD, primary care, case management, and housing services.

Please find below a summary of many of our partnerships throughout the communities we serve:

In **Brockton**- CCN is the CSA for the region. CCN also has strong relationships and MOUs with Signature Healthcare Brockton Hospital and Good Samaritan Medical Center, which includes working with Brockton Hospital's CHART program and providing recovery coaches to both Emergency Departments for patients experiencing an overdose. CCN provides the Recovery Coach training for community organizations within the Southeast area. CCN has advisory and board membership with Good Samaritan Medical Center, Brockton Neighborhood Health Center, and Massasoit Community College. We also provide clinical services with the Brockton parole office. We collaborate with housing and advocacy groups, including Brockton Housing Authority (for which the CCN operates a tenant service coordination program), 8 employment and education organizations, and Brockton Area Workforce Investment Board membership.

In **Taunton**- CCN coordinates with Taunton Drug Court (juvenile and adult), is an active member of the Taunton Opioid Task Force and Middleboro Matters (a substance use disorders [SUD] collaborative meeting). CCN attends the DCF/DMH/DYS Southeast interagency meeting, and been utilized as a consultant for interagency youth with complex substance use challenges.

In **Wareham**- Our staff participates on local coalitions and task forces, including the Wareham Chapter for Mass Association for Community Action and the Wareham Community Development and Economic Development Authority, and provides ESP services, in addition to Recovery Coaches in the Emergency Department at Tobey Hospital.

In **Attleboro**- We participate on the Attleboro Opioid Task Force and area CHNA, Systems of Care, Recovery Learning Community, and Parent Information Network.

In **Plymouth**- CCN is the CSA for the region. We are partners in numerous community groups, including the Plymouth Substance Use Disorder Task Force, Plymouth Drug Court, South Shore Partner in Prevention, CHNA 23, Systems of Care, Parent Advocacy League (PAL), Community

Correction Center, and the Plymouth County Outreach Initiative, an interagency program coordinated by multiple police departments, which provides urgent outreach services to SUD clients and their families after experiencing an overdose.

In **New Bedford**- CCN is the CSA for this region as well. CCN staff actively participates on the Homeless Providers Network, Greater New Bedford Allies, CHNA, the Mental Health Providers Network of New Bedford, and the New Bedford Opioid Task Force. CCN is part of the DCF Substance Abuse Consultation Team.

In **Fall River**- CCN is a participant of the Fall River Homeless Service Providers, Mayor's Taskforce 10-year plan to end homelessness, Substance Abuse Task Force, HIV Tobacco Education Coordinator Meeting, Regional Substance Use Disorder, Fall River Youth Violence Prevention Initiative meetings, and the Family Recovery Project Regional Council. Partnerships include the Commission on Grandparents Raising Grandchildren and Opioid Task Force.

In **Quincy**- CCN offers SUD services and BH support at Father Bill's and MainSpring homeless shelters, Manet Community Health Center, Quincy Drug Court, Quincy Mental Health Court, Germantown Neighborhood Center, Impact Quincy, New Way Recovery Center, and Quincy Family Resource Center. Recovery coaches are provided to Quincy Medical Center, Carney Hospital, and South Shore Hospitals. CCN provides SUD education to Quincy Public Schools. We facilitate/coordinate several parent and family supports, including Sober Mommies Group, and Learn 2 Cope (family support for loved ones with SUD). We participate in community forums: 3 SUD task forces (Quincy, Hull, and Scituate), Asian Link Task Force, and CHNA 20.

In **Barnstable County**- CCN maintains relationships with organizations, including housing, legal, and behavioral health and homelessness consortia. Cross-referrals occur with the regional peer-run recovery center, peer housing, and other recovery support groups. Primary care is provided weekly at the emergency adult shelter. CCN is a provider at Barnstable County Correctional Facility for inmates about to re-enter the community. Recovery support navigators and clinicians provide services at the local Emergency Department. Partnerships include Barnstable County Housing Coalition, Grandparents Raising Grandchildren Task Force, and Advisory Board for Child Advocacy Coalition.

B2. CCN will increase connection to communities within service areas by continued attendance at local coalitions, networking activities, and staff meetings to inform the community of CCN services, as well as become informed of their services and how they can assist in the delivery of CP supports and activities. Relationship-building will occur on all personnel levels to address systemic issues to providing direct services. CCN will develop and maintain a comprehensive website; extensive collection of marketing materials, and provide community education forums.

B3. The CCN's leadership team will meet regularly to share information, including new resources and opportunities. Each partner will orient staff about resources. Each partner will have regular staff meetings, trainings, and educational forums that focus on community resources. Care coordinators will be encouraged to share information with colleagues. CCN will ensure staff is provided access to an electronic resource database, as well as a written handbook that identifies community resources. As staff becomes aware of resources, the electronic database and the printed resource handbook will be updated accordingly.

7.3C Community Partner Supports and Activities

7.3C Community Partner Supports and Activities (15-pages)

For many individuals with BH, Substance Use Disorder (SUD), and/or homelessness, navigating the complex and evolving BH system can be overwhelming and at times disheartening. We recognize that these individuals need a clear path, guidance, and direction to access services in order to develop community and clinical supports that are not duplicative. The BHCP initiative provides resources, supports, and critical components to ensure that Enrollees have access to services that best fit their needs.

The BHCP is not one intervention; it is a progression of interventions culminating in a comprehensive partnership to support the whole person. The key components that are offered begin with outreach and active engagement, which result in the completion of a comprehensive assessment and Person-Centered Treatment Plan. Based on the Person-Centered Treatment Plan, the Care Coordinator, with oversight from the Care Manager, will bring together a care team for the Enrollee that will address Care Transitions, Medication Reconciliation, Health and Wellness, Care Coordination and Management, Coaching, and Connections to Community and Social Services. These components provide a clear road map for the Enrollee and his or her team.

The following is a detailed description of how each of the components will be operationalized:

7.3 C1. Outreach and Active Engagement

Effective outreach is critical to the success of the BHCP. Care coordinators and care managers will be the first to reach out to the Enrollee and encourage his or her participation in the BHCP. This first contact must be strengths-based, supportive, and positive, so that the Enrollee understands that this service is unique and unlike other services previously experienced.

In order to accomplish successful outreach, CCN is first and foremost committed to a skilled workforce with comprehensive Care Coordinator training. Research indicates that positive experience with care coordination is directly related to more positive health care appraisal and fewer unmet needs. Satisfied Enrollees are more likely to follow treatment plans, continue regular health care services, seek continuity of care, and disclose critical information.[1] For this reason, staff training will include evidence-based practices including motivational interviewing, recovery coaching, relationship-building, effective communication strategies based in recovery-oriented principles, and trauma-informed care.

We understand that locating and engaging individuals will be a challenge in some cases, and we recognize that we must be fully committed to making that connection with each Assigned Enrollee. We will closely monitor outreach and engagement activities to ascertain the most effective methods. The Care Coordinator with his/her supervisor will discuss creative ways to reach the Enrollees given their history and experience. All outreach efforts will be documented in the electronic care management system (eCMS) and integrated in the outcomes management. CCN seeks to achieve active engagement and is committed to at least one outreach activity within 30 days of referral and one face to face contact within three months**. (See Process Flow Attachment at end of this section).**

[1] Care Coordination Experience of People with Disabilities Enrolled in Medicaid Managed Care, University of Illinois, Department of Disability and Human Development, 2016

a. Strategies to outreach/engage with Assigned Enrollees, including individuals who are homeless and hard to reach, within the specified timeframes:
There are numerous social determinants of health that directly impact the Enrollee's ability to participate; homelessness can be one of the most challenging to effectively address. CCN is fully committed to reaching all Assigned Enrollees and recognizes the challenges that are inherent with the population served. Our first strategy in outreach to those who are homeless and hard to reach is to employ Care Coordinators with lived experience of homelessness, as well as other social determinants of health to bring creativity, confidence, commitment, and ingenuity to reaching and engaging those individuals.

Additional strategies for outreach include telephone contact/texting, social media, visiting locations where the Enrollee may be getting support services (e.g., recovery learning centers and clubhouses, food pantries, soup kitchens, day programs), contacting current or prior providers (if available and known), visiting local shelters, and working collaboratively with state agencies and the ACOs/MCOs. The Care Coordinator will follow the EOHHS-approved protocol for Outreach and Active Engagement with Enrollees.

For individuals experiencing homelessness, we understand that participating in the BHCP may not be a priority when their basic needs are not being met. Assisting Enrollees to access needed resources to assist in meeting their basic needs can be the first step in developing a relationship of trust and subsequently moving toward more formal care coordination. The Care Coordinator will work with other members of the Care Team, as well as access other community resources to address the Enrollee's immediate needs to aid in the engagement process.

Outreach by visiting locations the Enrollee is known to reside or frequent is especially important for persons that are homeless or at risk of homelessness. A significant strength of CCN is our commitment to and understanding of the communities we serve and the relationships that we have built. Together, our network has over 250 years of experience and expertise in the identified area. We will leverage our longstanding community and business relationships, in addition to share and maximize resources to expand our ability to reach those who would most benefit from the BHCP care coordination.

b. Strategies to outreach and engage Assigned Enrollees with SUD:
HPTC as the lead agency of CCN has extensive, broad-based experience supporting individuals with SUD. Its knowledge and expertise combined with that of all CCN partners, makes this population one with which we are confident of our ability to reach and serve. Collectively, we have trained and employed over 100 individuals in recovery as Recovery Coaches. The 5-Day Recovery Coach training that our recovery coaches have participated in has built a solid foundation upon which to assist, support, and engage individuals experiencing SUD.

Offering a recovery coach is our first strategy to support individuals with SUD. Recovery coaches offer outreach through a number of recovery services, including recovery centers, Self-Help/12 step meetings, as well as numerous SUD treatment services. Recovery coach Care Coordinators have a deep working knowledge of these resources, as well as the communities and locations where individuals with SUD reside. Recovery Coaches' lived experience and comfort

in reaching out to this population has proven to bolster the confidence, acceptance, and respect of Care Coordinators. Working in partnership to reach individuals with their own life circumstances in a myriad of locations and doing so without judgment, is of critical importance when attempting to engage with this population.

c. Process to obtain and document agreement to participate, signing Participation Form:

Taking time to carefully explain BHCP services and their unique features and benefits will be the first step in engaging the Enrollee and signing the Participation Form. CCN's brochure and literature will (in preferred language) provide a program description, delineate the process and options, and respond to common questions. These documents will be designed to open dialogue between the Care Coordinator and Assigned Enrollee. Encouraging questions, being transparent and patient, clearly explaining how BHCP support will be different from other/prior services will be instrumental in engaging the Enrollee. We understand that it may take multiple outreach attempts, in addition to face to face meetings with the Enrollee to develop rapport and assist him/her in making a decision to participate. Committing time and making a positive connection is a valuable investment in the relationship, allowing the individual to fully understand available supports and benefits, thus engaging with confidence and remaining engaged to fully utilize the services.

Once this is achieved, the Care Coordinator will have the individual sign a Participation Form, and explain that this confirms agreement to participate in the BHCP program. This step will move the individual from 'Assigned' to 'Engaged' status, allowing the Comprehensive Assessment (CA) to begin. The Care Coordinator will carefully review Protected Health Information (PHI) and how information will be shared. CCN intends to obtain, use, and share PHI as agreed to by the Enrollee, in accordance to its developed plan and pursuant to Section 4.1.A.3.i.with input from EOHHS and the ACOs/MCOs. The signed Participation Form will be scanned and filed in the eCMS. Upon confirming their commitment to participate, the Care Coordinator will begin the CA or based on preference, immediately set up an appointment to do so, bringing together the Enrollee's Care Team.

7.3 C2. Comprehensive Assessment and Person-Centered Treatment Plan

a. Comprehensive Assessment (CA):

The Comprehensive Assessment process begins immediately upon enrollment if the Enrollee has not had an active CA within 3 months prior to enrollment. In all situations, however, members of the Care Plan (CP) Team, which includes the Clinical Care Manager, the assigned Care Coordinator, and others who may be involved/working with the Enrollee with his/her consent, will work collaboratively to either develop the CA or assure implementation of the existing CA. The CCN Team will gather information to get a holistic and inclusive understanding of the individual, his/her life story, and the impact of illnesses on his/her life across a number of domains using the Massachusetts Standardized Documentation Project (MSDP) CA (as approved by EOHHS). To assure an inclusive approach, information is sought from many sources (with consent) including medical record documentation; referral information; narrative from the Enrollee; family members/friends/natural supports, and/or Legally Authorized Representative (LAR), if applicable; and previous and/or current treatment providers. As much as possible, Enrollee information is sought to verify information that has already been documented, as well as to achieve the most complete understanding of current status and life circumstance with regard

to physical, behavioral health, and a number of psychosocial needs. This process is essential in order for the CP Team to assist the Enrollee in navigating the behavioral health and health care system, improve continuity of care, coordinate and integrate care, and support principles of recovery.

Developing rapport is essential to engagement, and active outreach will help facilitate the process to assure a comprehensive view. To begin, a member of the CP Team, best suited to facilitate information-sharing, will meet with the Enrollee face to face. As the process unfolds, methods of communication most effective for the individual and others involved will be utilized, including phone and electronic methods. The CA will be completed within the first 3 months of the Enrollee's admission, with a minimum of one contact within the first 30 days of enrollment and as needed over the subsequent two months to complete the process. Information is collected from current and previous providers, including, but not limited to, the Enrollee's referral source (ACO/MCO), PCP/designee, specialty medical and behavioral health providers, housing providers, case managers, CBFS provider (if applicable), as well as other sources, including state agencies, such as DMH, DDS, DYS, DCF, OCCS, MCB, and MRC. The CP Team RN will review medical documentation/information and medical history, medical needs, and current medication list.

The EOHHS-approved CA tool will consist of information about and evaluation of presenting concerns and immediate care needs: current living situation, housing security/risk of homelessness and housing preference, family medical history, Enrollee medical history, current medical needs and current medications, social support, religion/spirituality, cultural/ethnic information, legal status/legal involvement history, education, employment, and meaningful activities, professional interests and goals, income and financial support, mental health and substance use treatment history and current needs. Current services include but are not limited to services provided by state agencies, ability to communicate care concerns, symptoms, and goals; a functional assessment of ADLs; self-identified strengths, weaknesses, interests, care goals, and personal goals; and accessibility needs, including preferred language, communication style, transportation, and equipment. CCN proposes to use the MSDP Adult Comprehensive Assessment (ACA) in electronic form to be consistent with that typically used across providers. The ACA includes all areas identified. Approval would be obtained from EOHHS prior to implementing this tool.

The CA will be reviewed and approved by the Licensed Clinical Care Manager, Registered Nurse (RN) and the PCP or PCP/designee. The Clinical Care Manager will distribute the finalized assessment to the other CP Team members, as well as PCPs, the ACO/MCO, and other service providers and state agencies involved in Enrollee care. The CA will be updated every six months, and if a significant clinical event occurs such as hospitalization, new/changed diagnosis, and/or change in a major psychosocial area that would impact services. The process is similar to that of the initial CA where the Enrollee and the CP Team work collaboratively to review changes in health status, services, and progress toward goals**. (Please see requested attachments of 'MSDP adult comprehensive assessment,' 'addictive behavior and substance use history addendum,' in addition to assessment tool 'PRAPARE' at the end of this section)**

2b.1-4 Process for Person-Centered Treatment Plans

Central to Person-Centered Treatment Planning is the genuine participation and collaboration with the individual, who has the best knowledge of his/her strengths, needs, and ideas for treatment goals and objectives. Engaging and supporting individuals through a strengths-based, person-centered planning process, unique to the person served, requires listening, understanding, and establishing rapport, maintaining a therapeutic relationship, and working in a collaborative manner. Peer specialists and/or recovery coaches are especially important in the assessment and treatment planning processes and can be extremely helpful when trying to engage the individual in planning and follow-through with his/her individualized plan.

The Person-Centered Treatment Plan is informed by the information gathered during the CA process and from other assessments conducted by current and previous service providers, such as the assessment of social needs. Each treatment plan will include a Personal Crisis Plan, which helps both the Enrollee and providers to understand ways to best support the individual in preventing a health crisis, as well as his/her needs during a crisis, which may be psychiatric, medical, or psychosocial in nature. The Person-Centered Treatment Plan and Personal Crisis Plan will be developed immediately following conclusion of the CA process and within three months of enrollment. As with the CA process, the CP Team works together with the Enrollee, as well as family members/natural supports, LAR (if applicable), and service providers, as appropriate, to develop an individualized, Person-Centered Treatment Plan.

The process of developing an individualized plan demands an environment of effective communication, open discussion, respect, and collaboration. It is not always completed in one session and must be thought of as a process. Meetings will accommodate the Enrollee and his/her support network, when practical. To support engagement and facilitate the individual in steering his/her treatment goals, a positive and hopeful atmosphere is provided throughout the process. A peer specialist or recovery coach can be particularly helpful in helping to solicit ideas from the Enrollee. CP Team members will be responsible for assisting in the development of goals, services, and interventions that are both clinically appropriate and acceptable to the Enrollee. The Person-Centered Treatment Plan will be approved by the Enrollee and his/her PCP. It will then be distributed to the CP Team, the PCP, ACO/MCO, and the Enrollee's service providers.

The individualized Person-Centered Treatment Plan includes several components. Contact information for the Enrollee, his/her PCP, and emergency contact is essential during the initial stage and must be maintained as changes occur. The type, frequency, and duration of services, as well as specific dates for re-evaluation are included. Essential to integrating care, the plan will convey how services will be coordinated among service providers of the Enrollee's Care Team. Short and long-term goals toward health and wellness are fundamental in establishing the treatment plan. Identification of barriers to meeting goals, goals to reduce risk, and manage complexity, and a review of the Enrollee's motivation and ability to adhere to the treatment plan are also crucial elements. As indicated earlier, the treatment plan will include a Personal Crisis Plan to be used by the Enrollee and members of his/her CP Team, as needed. A natural outcome of working collaboratively with the Enrollee during the treatment planning process is to fully understand personal preferences, needs, strengths, and cultural considerations, which will be the underpinning of continued engagement and success.

The written plan will be provided to the Enrollee in his/her primary language. If an LAR or other support is involved, the plan will be translated into the Enrollee's primary language. Translation/interpreter services will be used when a language barrier exists and/or the assigned Care Coordinator is unable to effectively communicate with the Enrollee or others involved. The CCN has access to 32 spoken languages within its network as well as translation/interpretation services of over 50 languages. If needed, alternative formats will be used to convey the content of the treatment plan, such as an audio or videotape. This assures understanding and informed consent and further inspires engagement and continuity of care.

The Person-Centered Treatment Plan will be reviewed at least every 6 months or from date of approval by the Enrollee's PCP, whichever is later. During the review process, the CP Team ascertains success of planned interventions and progress toward identified goals. Treatment plan review includes determining progress toward goals, assessing the Enrollee's health status, and reassessing the plan goals and interventions, in addition to determining the level of compliance with the plan, recommendations for follow-up, and updating the plan as needed. The plan will be rewritten at least annually. As with the initial plan, any revised or rewritten plan will be approved by the Enrollee's PCP and distributed to his/her ACO/MCO, PCP, Care Team, and outside service providers. The plan can be revised or rewritten at the review period or at any time the individual's needs change. During this process, the Enrollee is always asked for input regarding services provided and their impact on Enrollee health and wellness recovery goals. Other members of the CP Team are consulted when reviewing progress toward goals. Changes due to physical health, symptoms of mental illness, or a functional decline would be evident from interaction and communication with the Enrollee, CP Team members, and collateral contacts. If more than one area of the Enrollee's health status changes, the CP Team would be convened to review the plan for needed changes and any changes made would be communicated in a timely fashion to those involved in the Enrollee's care. **(See Process Flow Attachment at the end of this section).**

7.3 C3. Care Coordination and Management

Effective care coordination is the cornerstone of the BHCP program. Research has demonstrated that "care coordination increases efficiency, improves clinical outcomes and patient satisfaction."[2] All CCN partners have experienced individuals served being overwhelmed, frustrated, and frightened by the complexity of navigating the medical, mental health, SUD, and social service systems. In preparing for the submission of this proposal, our network discussed these challenges at length and how best we ensure that those in the Southern region and Greater Boston region would have the support and resources necessary to successfully navigate these often complex systems. The CCN partners have extensive experience and a deep commitment to providing effective care coordination. We recognize that in taking a collaborative approach, our efforts will be all-encompassing and extend to PCPs, other providers/programs, social services, community resources, collaterals, state agencies, peer networks, MCOs/ACOs, and most importantly, to the Enrollees.

a. Identifying all stakeholders involved in an Enrollee's care

The Care Coordinator will use the CA process to identify all stakeholders involved in the Enrollee's care. The assessment is the first step in understanding the Enrollee's treatment

[2] SAMSHA www.integration.samsha.gov

experience, use of natural and peer supports, current/past treatment providers, state services, social services, and most importantly his/her preferences. It is critical that the Care Coordinator takes the time to develop a trusting and supportive relationship with the Enrollee during the outreach and engagement process. Experience has taught us that simply gathering data without developing a strong connection will not build the necessary foundation for effective care coordination and team process. Carefully and thoughtfully identifying all stakeholders, including family, friends and other formal and natural supports will improve collaboration, avoid duplication of care coordination services, and best support the individual.

b. Exchange of information with such stakeholders:

The Care Coordinator will obtain signed Releases of Information that comply with state and federal laws from all identified supports. The Care Coordinator works with the Enrollee to identify individuals and organizations to participate on his/her Care Team. The Care Coordinator will be responsible to notify all stakeholders of the BHCP services and invite their participation in the care planning meeting(s). The eCMS will have functionality to exchange information and care plans with ACOs/MCOs and potentially with other authorized key stakeholders, including Care Team members. The Mass HIway and e-mail encryption will also be used for purposes of secure information exchange with providers and stakeholders. Recognizing the diversity of resources and applications utilized for the hundreds of potential stakeholders, CCN will interface with the stakeholders on behalf of Enrollees. We are poised to exchange information by utilizing an eCMS that is specifically designed to meet all required specifications and is configurable to meet service needs.

c. Identification and organization of the Enrollee's Care Team:

Together, the Care Coordinator and the Enrollee will decide who will participate on the Care Team. The Care Coordinator will strongly encourage the PCP or PCP designee, Clinical Care Manager, behavioral health clinician, and, as appropriate, family members, specialty clinicians, informal caregivers/natural supports, advocates, state agencies, peer supports, and community organizations as well as LTSS and CBFS providers, to be part of the Enrollee's Care Team. However, we respect that the Enrollee is in charge of who participates on his or her team. Honoring preferences is paramount to sustained engagement.

Experience has taught us that Enrollees may be hesitant to initially include multiple people on their Care Teams. The Care Coordinator will continuously work with the Enrollee to understand and address concerns related to who attends their Care Team meetings. These will include inviting others as needed, based on identified needs at any given time, and topics to be discussed. When the Enrollee is ready, the Care Coordinator will invite additional supports to participate. It should be noted that we do not view the Care Team as a static group. It is an evolving and growing support system for the Enrollee and will likely change and develop over time. With positive Care Team meeting experiences, we expect an Enrollee to be more deeply engaged and excited to ad supports to his/her team. It is the balance between careful listening to the Enrollee's needs and preferences and the development of relevant care plan goals that will enable us to build, with the Enrollee, an effective Care Team. Care Team meetings will be scheduled at a convenient time for those participating and be held at easily accessible locations. Conference call capability and electronic communication such as Skype will also be used, when appropriate.

When input from an important stakeholder is needed and the person is either unable to attend or the Enrollee doesn't wish to include him/her, a written report or status update will be requested for inclusion in the planning process, as authorized by the Enrollee.

d. Ensuring ongoing, effective communication across stakeholders, including documentation:
The Care Coordinator will be responsible for ensuring ongoing communication and the exchange of essential, required documentation, including keeping the team and collateral contacts informed of the Enrollee's progress, with the Enrollee's authorization. Consents will be signed at the time of engagement and periodically, as needed. eCMS will be utilized when possible for access to Care Plan updates and alerts as well as access for the Enrollee through the "Enrollee Portal."

7.3 C4. Care Transitions:
Transition between the many types and levels of care within our behavioral health/health care system is often perplexing and confusing for Enrollees and their families. The system is often fragmented, resulting in unintended barriers for Enrollees and those who support them in managing their behavioral health/health care needs. Navigating the system can raise questions about who is responsible for various aspects of care, how and when to take medications, which treatment recommendations are most important, scheduling and accessing transportation, interacting with various communication systems, cultural and language barriers, and/or lack of understanding treatment planning and options available. The goal of effective care transitioning is to assist the Enrollee and his/her family, caregivers, and support network to moving seamlessly from one level of care to another and from one provider to another in a way that prevents unnecessary complications and setbacks for the Enrollee, thereby improving overall care continuity.

Clear communication and effective information transfer is pivotal. Studies indicate that an optimal transition should be well-planned and adequately timed and that communication between settings or providers often fails to supply all of the information needed for optimum care.[3] Care transition plans are therefore an important defense, reducing and preventing medical/medication errors, facilitating prevention and early intervention strategies, avoiding unnecessary hospitalizations/re-admissions, enhancing the efficient use of resources and available support, and most importantly, honoring the Enrollee and improving satisfaction. Care Transition Planning facilitates the coordination of medical and LTSS when an Enrollee has been admitted to a hospital for medical care, discharged from a hospital to a long-term care setting, such as a skilled nursing facility or inpatient rehabilitation facility, or discharged to a community-based long-term care setting.

All CCN partners have utilized Care Transition Plans with individuals and families over the past several years. Initiatives include Community Support Programs (CSPs), Community Service Agencies (CSAs), and other care coordination/case management programs. For example, when an individual is stepping down from an inpatient Clinical Stabilization Service, CSP staff can assist the SMI/SUD individual prior to discharge in stepping down to a less intensive level of care, such as outpatient services. This support can make the transition to outpatient far less stressful and confusing for the individual and family members and increases the likelihood

[3] Improving Transitions of Care: Hospital to Home; National Transitions of Care Coalition; October 2009

he/she will keep the outpatient appointment. Bridge visits for specific MCOs create an opportunity for an outpatient clinician to participate in the inpatient aftercare plan while the Enrollee is still inpatient to address barriers that may inhibit follow-through with recommended services. Transitional services give the individual and family an additional opportunity to address their concerns in taking next steps and identify solutions that result for successful transition to another provider or level of care. High Point Treatment Center, Bay State Community Services, and Brockton Area Multi Services, Inc. are currently involved in two pilot programs that involve four additional agencies, including two local hospitals and community-based BH programs that are collaborating and utilizing Clinical Care Documentation (CCD) electronically transmitted to the subsequent provider for referral and on the day of discharge. Utilizing electronic exchange of data and Protected Health Information (PHI) through transitions will assure and improve coordination of care among and across the Care Team.

Care transition support will be extended to Enrollees as a CP activity. The Care Coordinator will contact the Enrollee's inpatient treatment team, the PCP, ACO/MCO, and participate in the development of an appropriate discharge plan, and be present at discharge planning meetings. The Care Coordinator will work in collaboration with the Enrollee and the ACO/MCO to ensure that potential barriers to following through with behavioral and medical health care needs, including but not limited to medication-related services, rehabilitation, and recovery support services are addressed. The Care Coordinator will assist in ensuring that the Enrollees' needs are communicated in a way that they and their family understand. Cognitive, cultural, and linguistic needs, as well as literacy and health literacy will be incorporated into verbal and written communications with the Enrollee.

The Care Coordinator will conduct a face to face visit with the Enrollee within 3 business days following an inpatient discharge or change in treatment setting, aiding through the transition process, utilizing evidence-based interventions designed to address the Enrollee's needs. The Care Coordinator will utilize motivational interviewing, an evidence-based practice that is designed to assist in engaging the SMI/SUD population. Engagement and establishing trust is an important first step in working with this population. Motivational interviewing emphasizes a person-centered approach, listening and working with individual's unique change talk. In addition to utilizing motivational interviewing, the Care Coordinator will be trained in the evidence-based practice/Stages of Change Model Prochaska and DiClemente[4]. This approach outlines the five stages of change that individuals move through during life transitions. Based on the Enrollee's level of motivation, ability to function in the community, and history of treatment experience, the Care Coordinator will utilize additional evidence-based models, including recovery coaching to assist in making positive changes toward recovery and wellness. A transition checklist will guide Care Coordinators, who will act as a hub to verify and clarify information exchanged between providers.

The Care Coordinator will be responsible for updating the Person-Centered Treatment Plan and documenting and electronically transmitting Clinical Care Documentation (CCD) to pertinent providers, including the ACO/MCO. The Care Coordinator will monitor needs, issues, and concerns and facilitate the coordination of clinical and support services during the care transition. Through consistent communication with the Enrollee, the Care Coordinator will continue to

[4] The Stages of Change Model; Prochaska and DiClemente; 1984

assess his/her motivation and readiness for change in each goal area of his/her Treatment Plan. The Care Coordinator will provide ongoing updates on the Enrollee's progress toward meeting treatment goals, identifying new barriers to accessing care, and challenges to community stability with all involved treatment providers, with regular contact and follow-up every step.

Throughout the engagement and implementation process, the Care Coordinator will have ongoing contact and will meet with the Enrollee based as appropriate. He/she will offer to accompany the Enrollee on initial visits/contact with treatment providers, facilitating a warm hand off and engagement with the new provider. The Care Coordinator will also ensure that the provider has access to health information through the CCD program or eCMS and facilitate additional communication when needed.

Throughout the transition process, the Care Coordinator will work with the Enrollee and his/her family, addressing barriers to ensure a smooth transition between levels of care, services, and providers based on the Enrollee's unique needs and preferences.

7.3 C5. Medication Reconciliation:

According to the U.S. Dept. of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ), communicating changes to medications after an inpatient stay is a major challenge for systems trying to coordinate and integrate care. The effectiveness of a sound medication reconciliation process within and among care settings is an important component of patient safety, improved transitions, and treatment success. AHRQ offers a variety of resources and tools for medication reconciliation. The medication reconciliation process for CCN will utilize components from emerging practices used in acute and community settings.

Medication reconciliation is a collaborative process between the CP RN, Enrollee, PCP, the pharmacist, discharging facility, and other ancillary health care professionals. As stated earlier, the CP RN collects a complete list of medications the Enrollee is taking upon enrollment. This comprehensive list should include prescribed medications, herbal supplements, over the counter medications, as well as any nutritional supplements. Each time an Enrollee is discharged from an inpatient stay, which can be a medical or psychiatric hospitalization, the CP RN will be responsible for conducting medication reconciliation. Discharge planning should be thought of as beginning at the time of an inpatient admission. Ideally, the RN starts the medication reconciliation process before discharge from a facility, so it is concluded upon discharge. The RN should have advance notice of a hospitalization when possible to best facilitate the process. Care coordinators may have knowledge of admissions from the Enrollee or from one of his/her service providers, or ACO/MCO. In this case, the Care Coordinator will assist the RN in attaining a targeted discharge date and a list of discharge medications. The timing of the medication reconciliation is vital so as not to create a gap in changes, additions, and deletions between medications being taken while the Enrollee is in the hospital and actual medications taken upon discharge of the inpatient stay. If full medication reconciliation cannot be completed before discharge, then the process will occur within 3 days of discharge.

Close to or upon discharge from an inpatient stay, the Care Coordinator will help to facilitate obtaining the medication list from the facility/prescriber. The RN reviews and compares the discharge medication list to the list of medications on record, which would be the list of

medications taken prior to admission. If there are no changes during the inpatient stay, the RN simply verifies and assures adequate supplies on hand. If there are medication changes, the RN will provide the Enrollee's PCP with the medication list in order to verify that the medication orders from the discharging facility/prescriber are appropriate given the Enrollee's overall health profile. Unintended discrepancies will be discussed with the physician and any resulting changes documented in a revised medication order. The PCP will review for unwanted medication interactions or side effects. The PCP will be able to identify medications that have been prescribed in the past with limited effect, or medications with which the Enrollee had poor adherence. The PCP will also need to know new medications that require special monitoring through lab work or symptom monitoring.

After the accuracy of the medication list is determined by the CP RN and approved by the PCP and other prescribers, the RN ensures that the medication orders are filled correctly. The RN can do this in a variety of ways, depending on the level of independence of the Enrollee. Some Enrollees who are independent may have already filled their prescriptions upon discharge. In this scenario, the RN would review the medication list and cross-reference with the pharmacist or the Enrollee's medication supply looking for discrepancies, and forward updates or changes to the PCP for further review and approval. At this point, if the prescribers do not want to make any changes, the record is edited, order obtained, and the Enrollee continues using as prescribed. If the prescriber has recommendations for change, the RN and Care Coordinator will facilitate a conversation and/or schedule an appointment between the Enrollee and the prescriber to discuss and come to agreement on changes. If the Enrollee has not filled his/her prescription(s), then the RN oversees the process of filling medication orders with the pharmacy with assistance of the Care Coordinator. Again, depending on the level of independence and functional ability of the Enrollee, the Care Coordinator may assist in the process. The Care Coordinator may also work with the Enrollee's Care Team and identify natural supports or skilled nursing for additional support.

The Enrollee will be counseled on any changes, additions, or deletions that were made to the medications. The new medication list will be provided to the Enrollee in a clear and understandable manner to encourage full medication compliance and prevent confusion or questions that may result in medication errors. The RN will confirm that the Enrollee demonstrates an understanding of what he/she is taking, why, and how he/she is taking it. The RN will review the medications with the Enrollee and discuss ideas to prevent non-compliance and to promote adherence to taking medications as prescribed. There are many effective strategies that the Enrollee can utilize as medication reminders. These include, but aren't limited to calendar reminders, telephone calls/text reminders/alerts, daily medication planners, electronic reminders such as smart phone "apps," and digital pill containers/dispensers, pharmacy provider medication bubble packs, and using natural supports such as family members and friends. Enrollees who require further support will be referred to a home health agency to assist with medication management. CP Team members will assist Enrollees in using one or more of these strategies and evaluate the success of each method during review periods.

Strategies to help organize and remember to take medications are effective and useful. However, research shows that individuals take medications as prescribed when they are motivated to do so. Motivational Interviewing has been widely used and adapted in psychiatric and medical

programs in order to help change behavior, like adhering to a medication regime. Other techniques will be used to encourage and support medication adherence, such as improving education related to diagnoses and medications, patient access to medical records, shared decision-making, and simplifying medication regimes. The RN can spot-check for medication compliance through a review of an Enrollee's blood pressure (if she/he is on medications for hypertension), review of blood sugars (if being treated for diabetes), and other checks, depending on medications and diagnosis. The RN can also confirm with the pharmacy that the medications are being filled and picked up according to the prescribed schedule.

If the Enrollee participates in a program utilizing DPH's Medication Administration Program (MAP), it is imperative that the CP Team provides an accurate, updated medication list and specific medication orders in the format required by MAP in a timely manner. The CP RN will have a working knowledge of MAP policy and procedures. Enrollees who participate in MAP live in residential programs, as well as independently in the community. They receive their medication from MAP-certified staff. For example, not having the correct prescriber's order will prevent staff from administering a needed medication. A delay in medications may not be safe for an individual. Medication occurrences can be prevented by the CP RN collaborating very closely with the MAP staff in these instances. Three of the CCN partners have extensive MAP experience.

7.3.C6. Health and Wellness Coaching:

a. Health and wellness education, coaching and health promotion

The CCN practices a person-centered approach when guiding each Enrollee toward achieving a healthy lifestyle, which is an important part of overall wellness and recovery from behavioral health disorders/SUD. This approach is guided by the MA Department of Mental Health's "Healthy Changes Initiative." This initiative was developed to address modifiable risk factors for chronic illness and health. The framework emphasizes improved health and wellness through screening, assessment, and providing evidence-based treatment planning throughout the system of care for nicotine addiction, obesity, and physical inactivity. The framework can easily be applied to other health and behavioral health conditions and goals. The underlying premise of integrating health and wellness coaching into treatment planning is that everyone benefits when Enrollees reach their optimum level of wellness, self-management, and functional capability, for the Enrollee, their families/support systems, the health care delivery systems, and various payer sources.

The Health Changes Initiative's structure of health and wellness in treatment planning is based on the following concepts:

- Healthy lifestyle is an attainable goal and an important part of overall wellness and recovery;
- Person-centered approach to health and wellness is key; and interventions must be culturally and linguistically sensitive;
- An individual's readiness to take action to move toward a healthy lifestyle is the basis for any goals, objectives, or interventions and is a method for measuring the process that people go through when they successfully make changes in their lives[5];

[5] The Stages of Change Model; Prochaska and DiClemente; 1984

- Motivational techniques can increase an individual's desire to take action, including motivational interviewing and motivational enhancement.

CCN recognizes that assisting an Enrollee in taking small steps toward healthy living is the best way to achieve lifestyle changes. Living a healthy life is a process that does not happen overnight. We are committed to training our care coordinators in this model, as well as other models that will be individualized for the Enrollee.

b. Goals for health and wellness recorded/tracked as part of Person-Centered Treatment Plan.
CCN's Health and Wellness Coaching is a collaborative process of working with the Enrollee and his/her support systems to specify personal wellness goals identified in treatment planning and the approach and means by which the Enrollee can reach his/her goals and reduce risks. Care coordinators trained in the Stages of Change Model will measure the process each Enrollee moves through when successfully making changes in his/her life. The 5 stages include pre-contemplative, contemplative, preparation, action, and maintenance. Care coordinators will utilize the evidence-based practice of motivational interviewing to elicit behavior change, helping members to explore and address potential ambivalence.

Including Enrollee health and wellness goals on his/her treatment plan begins with the CA and identifying the targeted health focus (e.g., increased exercise, improved nutrition, smoking cessation, weight loss, and chronic disease self-management, etc.). Once a health focus is identified, the care coordinator, working collaboratively with the Enrollee and Care Team, will establish long-term health focused goals and will record this in the eCMS. The Care Coordinator then guides the Enrollee with identifying and developing short-term goals with small achievable steps that will ultimately lead toward achievement of the long-term goal(s). Through small actionable steps, risk is progressively reduced, and the Enrollee begins to gain confidence, hope, and improved health and wellness. Goals are always personalized to the individual, considering his/her stage of change, and identify observable, measurable, and quantifiable behaviors the Enrollee will demonstrate, which are recorded/tracked in the Person-Centered Treatment Plan. An example of a short-term goal used to achieve the long-term goal of improving health outcomes may be participation in exercise 3 days/week for 30 minutes each time. The Care Coordinator would support the Enrollee to identify the best intervention to achieve the goal and connect the member to needed resources, such as transportation to/from the YMCA/YWCA or another location, obtain a free or low cost membership, and/or engage a "buddy" for support.

In addition to wellness planning, the Care Coordinator will provide ongoing health education on methods/strategies to reduce high risk behaviors and symptom management harm reduction, as well as assess other health risk factors. The Care Coordinator will provide coaching and education on chronic disease self-management and work with all providers to support coordinated efforts around unified goals.

7.3. C7. Connection to Community and Social Services:
In order to be effective, CCN will incorporate all the Guiding Principles and Elements of Recovery Oriented System of Care published by the Substance Abuse and Mental Health Service Administration (SAMHSA) and the Center for Substance Abuse Treatment (CSAT). These best and promising practices provide us with 12 guiding principles and 17 elements to which CCN is

committed. Recognizing that there are many paths to recovery, these guiding principles prioritize the belief that recovery is holistic and "recovery involves (re) joining and (re) building a life in a community." It is the responsibility of the Care Coordinator to ensure that each Enrollee has a realistic and sustainable plan that includes community and social supports.

CCN will implement a multi-tiered approach to ensure ongoing connections to community resources and social services. To address social determinants of health, we propose to implement the protocol for responding and Assessing Patient Assets, Risks and Experiences (PRAPARE), a social needs assessment developed by the National Association of Community Health Centers. Pending EOHHS review/approval, this tool will be used to identify areas of concern related to social determinants of health and will guide the Care Coordinator in identifying resources, best practices, and lessons learned to aid in the development of appropriate social service goals. A self-report questionnaire will also be used to address the need for community-based, social, and flexible services outlined in Attachment A; 2.3G.

While these tools are helpful, they do not replace the essential dialogue that must take place between the Enrollee and the Care Coordinator. Therefore, the second step in addressing social needs is taking time to explore the Enrollee's experience to best understand which resources would be most helpful and accepted. We know that Enrollees may be wary to access certain community resources. In this case, it may be beneficial to work through concerns, if indicated. To effectively use and benefit from community support/resources, the Enrollee must feel safe and express his/her preference. The Care Coordinator will assess the benefits of working with the Enrollee to return to a previous support or identify new supports based on identified strengths and needs. An important lesson learned is that too many referrals can be overwhelming and counterproductive. Careful selection with the Enrollee and providing choices that directly address care plan needs will serve to increase participation and desired outcomes.

Lastly, once the Enrollee has agreed to access a community support, a warm hand-off will be used. This is critical to ensuring the Enrollee's attendance and best use of the identified resource. The Care Coordinator will join the Enrollee on his/her first visit whenever possible to introduce the Enrollee to the recovery coaches in the recovery centers, staff at day programs, employers, case managers in the housing support programs, community support or health care workers, Self-help group members, and wellness and direct care staff at recreation facilities, to name some. The benefit of a warm hand-off is for the Care Coordinator to return to that location and meet with the Enrollee if appropriate, such as scheduling a meeting at a recovery center or any other community location that will support the Enrollee's continued participation. This also gives the Care Coordinator ability to see how the support is working and whether the needs are met or should be re-evaluated. Care coordinators will facilitate referrals and assist in making appointments, obtain PT 1, or aid in navigating public transportation. The strength of CCN is our extensive knowledge and experience in accessing the community and social services throughout all of our service areas.

7.3D Innovative Technologies for Service Delivery

7.3D Innovative Technologies for Service Delivery (1 page)

The planned use of technological tools pertaining to the CCN will utilize methods like telehealth, tablets, laptops, air cards, billing integrations, and customized interfaces to an Electronic Care Manager System (eCMS). Telehealth encompasses a wide variety of technologies and tactics to deliver virtual medical, psychological, SUD, health, and education services. Telehealth is not a specific service, but a collective means to enhance care and education delivery. The goal of this contract is effective care coordination, which will utilize tools to support Enrollees. In the event a Care Coordinator is not accessible due to unforeseen circumstances (emergency or severe weather), the CCN will utilize technology to maintain service delivery. The technologies for telehealth will include a variety of services, including HIPAA complaint video, secure text, and phone contact. Each of these means of communication carries its own level of privacy safeguards, including encryption at rest, in transit, and anonymous keys used in message decryption. These safeguards pertain to all forms of telehealth using products from Open Whisper System, Doxy.Me, and more.

Other technologies that will be used to support service delivery include a combination of tablets, laptops, and desktop computers. Currently, High Point Treatment Center (HPTC) uses tablets for QR scanning of client bracelets, safety (room) checks, dietary ordering, groups, and patient kiosks for dose change requests, and dosing check-in. Much of this is accomplished using a custom-built interface that links software developed in-house to the SQL database housing all the Electronic Medical Record (EMR) data. Creating such interfaces allows quicker access to information, easier input to the system, and a more streamlined workflow process, all aiding overall patient care. These strategies will be applied to the needs of the CCN Enrollees. Tablets in the scope of the contract will be used for Electronic Care Manager System (eCMS) access, as well as additional applications our eCMS vendor develops to work with the current EMR platforms or the CareManager application. A combination of laptops and desktops will document within the eCMS remotely, internally, or while traveling to see Enrollees. In conjunction with tablets and laptops, a third technology will be introduced for users working while traveling or where wireless Internet is not accessible. Air cards/hot spots will be used to bridge the gap of no connectivity and remote work by using a secure cellular connection to either an eCMS or EMR using VPN service for direct connection.

CCN is researching care management software products and will work to finalize a vendor by 8/15/17 and configuration by 2/1/18 as referenced in 7.3A4 Implementation Plan. Currently, HPTC utilizes Netsmart's TIER application, which offers great flexibility and customization to best suit the needs of its workflow. Due to its customizable nature, several enhancements have been made, helping HPTC to become one of the first customers to utilize the entire company's billing process thru the EMR, using a combination of interfaces and direct messages to payers. In addition to billing, the HPTC Electronic Care Manager System (eCMS) product has been customized to accept custom-built applications such as a medication reminder system, alert notifications, pharmacy medication management, room checks, labels, qr code generation wristbands, and dietary management of clients. Augmented/facilitated communication devices and adaptive equipment will be accessed to support Enrollees' health, mobility, and communication needs. Several partners have experience in these areas. The goal is for the CCN partners to utilize this same care management platform to easily communicate care and support Enrollees.

7.3 E Personnel and Staffing

7.3 E Personnel and Staffing (5 pages)

E1. Organizational chart attached at the end of the section.

E2. A Sample Staffing Model for the number of Engaged Enrollees in each Service Area as indicated in Attachment D, including number of FTEs for supervision, administration, and Care Management and Care Coordination positions.

Service Area	Year 1	FTE Supervisors	FTE Administration	FTE Care Manager/Care Coordinators
Attleboro	500	.35	.75	13.49
Barnstable	740	.52	1.11	19.99
Brockton	1,700	1.19	2.55	45.91
Fall River	640	.45	.96	17.28
Falmouth	350	.24	.52	9.44
New Bedford	2,240	1.57	3.36	60.48
Orleans	100	.07	.15	2.71
Plymouth	750	.52	1.12	20.25
Quincy	650	.45	.97	17.54
Taunton	700	.49	1.05	18.91
Wareham	350	.24	.52	9.44
Total	8720	6.10	13.08	235.44

E3. A description of Bidder's recruitment plans, including timelines to recruit staff for any personnel positions not currently filled, and job descriptions and qualifications for each personnel position.

As a new initiative, we recognize that there will need to be a great deal of time and energy spent recruiting all levels of staff in order to effectively launch the BHCP services as required by the RFR. We will capitalize on the strengths of our partner agencies' reputations, resources, and creativity to ensure that we successfully staff all the positions within the required timelines.

The process of hiring staff will begin as soon as a signed contract is completed. The first strategy for each CCN partner will be to assess current staff and determine if it has the appropriate credentials and the desire to be considered for these new positions. Simultaneously, we will begin the process of advertising, interviewing, and hiring for the positions.

As a Network, we will work collaboratively together to ensure that all interested candidates will be reviewed for credentials, experience, and desired location of work in a timely fashion so that no candidate is overlooked.

Each of the partners will employ a recruiter to support the BHCP Initiative. The following strategies will be employed to find and hire quality staff: Positions will be posted on Smart Recruiters. The platform for Smart Recruiters then filters all the positions to Indeed. In addition, positions will be posted on sites, including but not limited to Idealist, Craigslist, college/university job boards, Facebook, Constant Contact, agencies' websites, as well as LinkedIn. CCN will also have a dedicated website that will have available positions posted for each partner.

In order to address the immediate need for numerous care managers, care coordinators, and management staff, CCN will offer three open house hiring fairs in strategic locations. These open houses will be a collaborative effort to hire employees for any of the CCN BHCP positions.

In addition to media outreach, each of the CCN recruiters will present at career centers, participate in college/university fairs, present in college/university classrooms, and target local colleges, including the University of Massachusetts, Boston University, Simmons College, Lesley University, Quincy College, Eastern Nazarene College, as well as other local colleges/universities with human services-related majors. These aggressive strategies will enable us to reach hundreds of potential candidates every day.

Critical to our staff development is the employment of individuals with lived experience. CCN recruiters will work closely with the local recovery centers, recovery learning communities, DPH-Recovery Coach Training program, DMH Peer Training program, and the University of Massachusetts' Addictions Certificate programs to reach individuals with lived experience. These community-based sites work with hundreds of individuals with lived experience looking to give back to their communities.

Job descriptions for the positions are attached at the end of the section.

Plans for Recruiting Care Coordinators	**Timeline**
Recruit internally from current staff.	December 2017 and ongoing
Present our care coordination services to Bachelor's level college and university classrooms in their psychology, sociology, criminal justice, and human services majors. Target colleges and universities, including Bridgewater State University, Boston College, Boston University, Simmons College, UMASS, Eastern Nazarene, and Lesley University.	February 2018
Attend all job fairs at major Bachelor's level colleges and universities.	Winter/Spring 2018
Use our internal staff to reach colleagues and qualified friends and relatives.	January 2018 and ongoing
Post the care coordinator positions on all major recruiting websites (such as Indeed, ZipRecruiter)	February 2018 and ongoing

Plan to Recruit Master's Level Supervisory Staff	Timeline
Identify qualified Masters level staff to interview.	February 2018 and ongoing
Attend all Masters level job fairs at major colleges and universities, as well as the NASW and LMHC job fairs.	Winter/Spring 2018
Use current supervisory staff to reach out to qualified colleagues to schedule interviews.	February 2018 and ongoing
Advertise in professional journals (NASW, LMHC, LMFT, and BSAS).	February 2018 and ongoing
Post supervisory positions on major recruiting websites.	February 2018 and ongoing

E4. How Bidder will recruit/hire staff from cultural/linguistic communities it intends to serve.

CCN is committed to hiring staff who reflect the communities we serve. We accomplish this by first knowing the needs and demographics of our communities and reaching out to our communities to encourage these individuals to apply for positions.

Our current staff is an excellent resource to recruit colleagues, friends, and relatives with language and cultural capacity, in addition to credentials for the care coordination positions. Several of the CCN partners give current employees a financial bonus for aiding in the recruitment process. We will advertise in local community bi-lingual newspapers, as well as social media, emphasizing our desire to hire a diverse staff. Several of the CCN members also reimburse bi-lingual individuals at a higher rate. In addition, the CCN members will recruit staff for the care coordination positions in and out of the United States, as well as advertise in overseas newspapers and on websites for bi-lingual staff.

E5. Proposed training, orientation plans, and modules:

A well-trained, confident, and qualified staff will be CCN's most valuable resource. Maintaining this type of staffing requires a commitment of the partner agencies to screen, interview, hire, and provide a comprehensive orientation, as well as ongoing training program. All CCN employees will participate in their specific agency's orientation and training program. Each BHCP will train its staff on the core competencies as outlined in 2.4 C and 7.3 C.

Each CCN partner will develop individualized training plans for its staff. All training programs will include intensive training in the following areas: Making Connections with Enrollees; Healthy Boundaries; Effective Outreach and Active Engagement Techniques; Coordinating a Care Team; Completing a Comprehensive Assessment; Developing a Person-Centered Treatment Plan; Effective Care Coordination; Care Management; Care Transitions; Medication Reconciliation; Coaching for Health and Wellness; and Collaborating with Medical Professionals. In addition, each CCN partner will train staff on the documentation requirements of his or her position including maintaining a secure medical record; completing releases of information; care management software; writing strengths-based Person-Centered Treatment Plans; and completing progress notes that will include date of contact, mode of communication or contact, identification of collateral, results of contact, and required signatures and approvals.

In order to be prepared for the June 1, 2018, start date, CCN plans to organize an Implementation Team in accordance with our timeline referenced in 7.3 A4. This team will be comprised of senior level individuals from each of the CCN partners who will be responsible for the oversight of the service. Together, team members will develop policies and procedures, staff curriculum, process systems, and work with the ACO/MCO to finalize implementation requirements.

Each Network partner will hire staff two weeks before program implementation to complete training and orientation. CCN anticipates hiring 82 individuals in order to operationalize the program on June 1st. Having this workforce together and taking this opportunity to offer a comprehensive training with all new employees will allow the Network to have a well-trained and prepared workforce.

In addition, all staff will have the opportunity to participate in the CCN's monthly training. This will ensure that all staff members employed for the Network have a solid understanding of the expectations, are offering consistent service, and have developed the skills needed to be successful in their positions. This will also provide staff members from the different CCN partners an opportunity to meet and understand that they are part of a larger system. These trainings will be offered on a rotating basis at each of the CCN Partners' sites. The trainings will consist of the following training modules:

Module 1- SHARE Curriculum

Developed by The Agency for Health Care Research and Quality (AHRQ) SHARE curriculum. This curriculum offers the best practices of providing care management.

Module 2- Motivational Interviewing

Module 3- Care Management Essentials, including

- Outreach and Active Engagement
- Comprehensive Assessment and Person-Centered Treatment Planning
- Formation of a Care Team
- Facilitation of a Care Team
- Care Transitions
- Medication Reconciliation
- Health and Wellness Coaching
- Connections to Community, Social, and Flexible Supports
- Community Collaboration and Coordination

Module 4- Cultural Competency

- Accessibility and Accommodations
- Independent Living and Recovery Principles
- MassHealth State Plan, LTSS, and Eligibility Criteria

Module 5- Trauma-Informed Care

E.6. Description of Staff Retention Strategies

As part of our staff retention strategy, we outline ways in which an employee can grow in his or her position in the BHCP initiative. Staff that has demonstrated proficiency with the required core competency will be given the opportunity to mentor new staff and/or current staff that may need additional support. Each new employee will be assigned to a team leader, who will provide additional training, shadowing opportunities, and support.

The workforce is the foundation of the BHCP. Retaining qualified staff is essential to providing effective and quality BHCP services. There are several factors that influence an employee's decision to remain in or leave a position. These include job satisfaction, professional development, decision-making process, manageable workload, and reasonable expectations (SAMHSA).

In order to address these issues, the CCN will implement the following retention strategies. The first retention strategy begins with leadership. Having committed, skilled, knowledgeable, and supportive leaders in the BHCP creates an atmosphere for staff to want to learn, grow, and perform to meet the needs of our Enrollees. The CCN has been designed with staff comprising a Program Director (1.37 FTE), Clinical Case Managers (5.48 FTE), Registered Nurses (10.96 FTE), and Care Coordinators with Masters (13.7 FTE). They will support Care Coordinators with Bachelors (46.58 FTE) and Admin./Billing (4.11 FTE).

The CCN's second retention strategy is to build a collaborative team approach. Having a team that the care coordinators can rely on and use for support and resources will reduce isolation and encourage collaboration, while reducing the potential for burn-out. The third strategy is to offer opportunities for growth. A Care Coordinator will have the opportunity to become a team leader, champion for training, or supervisor, depending upon his or her degree.

Another retention strategy is to develop and maintain a robust training program. Experience and research has shown that when staff has training and certification opportunities such as becoming a recovery coach, receiving a trauma-informed certificate, and/or obtaining CEUs to maintain licensure, they are less inclined to leave for other opportunities. In addition, the CCN is committed to hiring individuals on a full-time basis with health, dental, and paid time off benefits.

CCN is also committed to a health and wellness initiative that has been implemented in many of our partner agencies, (e.g. eye doctors on-site, sharing healthy newsletter recipes, walking challenges, annual wellness and needs survey). This model would be adapted for the BHCP program.

7.3 F. Implementation Plan and Timeline

7.3 F. Implementation Plan and Timeline

Preparation Budget Period (Ongoing - May 2018)

August 2017

- Research and select care management software.

September- December 2017

- Meet with Affiliated Partners regularly
- Complete required paperwork from MassHealth

February 2018

- Identify potential office and meeting space in existing provider network of office locations.
- Identify members who will comprise committees, including Executive, Quality, Network Operations, and HR and Training.
- The following committees will begin meeting monthly: Executive Committee, Quality Management Committee, Human Resources and Training Committee, and Network Operations Committee.
- Begin configuring care management tool.

March 2018

- Continue configuring care management tool.
- Complete minor renovations of existing office space as needed. Minimal work is anticipated.
- Program Manager/Senior Manager begins work on project. Program Manager is a current High Point employee who will be reassigned.
- Continue outreach to designated MCO/ACOs to negotiate elements of contractual agreements.
- Further develop staff recruitment plan that utilizes various types of media.
- Develop training curriculum about roles and responsibilities for the Consumer Advisory Board (CAB).
- Develop staff training plan that delineates dates, locations, and instructors.
- Begin creating a website for Enrollee use.

April 2018

- Complete configuring care management tool.
- Develop policies and procedures for information sharing, Electronic Health Record utilization, and Mass HIway connection.
- Enrollee informational material developed in most prevalent languages and alternative formats.
- Staff training curriculum is developed and completed for all required areas.
- Computers, tablets, and telephone configuration completed.
- Ensure full compliance with Readiness Review responsibilities.
- Complete Continuity of Operations Plan.
- Budget report and narrative submitted for EOHHS approval.

- Begin furniture, equipment, office, and program supplies purchases.

May 2018

- Website completed.
- Execute contractual agreements with ACOs and MCOs.
- Conflict of Interest Policy is developed and approved by EOHHS.
- Grievance Policy and Procedure is developed and approved by EOHHS.
- Assigned or Engaged Enrollee Rights Policy is developed and approved by EOHHS.
- Continue recruiting staff positions, utilizing internal and external job postings, career fairs, etc. Complete background checks.
- Develop the following forms: Participation Form, Discharge/Transition Plan, Transitions in Care Checklist, Person-Centered Treatment Plan, Medication Reconciliation Form, and Social Services Assessment. Obtain EOHHS approval for the Comprehensive Assessment and other forms as required.
- Finish Furniture, equipment, office, and program supplies purchases.
- Program Director, Clinical Care Managers, Registered Nurses, Care Coordinators, Administrative Assistant, Intake and Billing Coordinators begin working May 2018.
- All staff receives training in areas required by the contract, attends each respective provider's standard orientation training, and is trained to use the care management tool. Training is completed by May 31, 2018.

Budget Period One (June1, 2018 - December 31, 2018)

June 2018 and ongoing

- Initial referral list provided by MassHealth. CCN acknowledges receipt of referrals within 1 business day. Referrals distributed to designated providers in each service area by May 2018.
- Outreach and intake efforts begin, Qualifying Activities begin, and Enrollees declining services are disengaged throughout the quarter.
- Notify EOHHS/MCOs/ACOs monthly of capacity to accept new referrals.
- Care Coordinator assigned within five business days. Care Plan completed for all Engaged Enrollees within 90 days of signing the Participation Form.
- Information about participating on the Consumer Advisory Board distributed to Enrollees.
- Monthly Member Status Reports completed. Submit record of all Qualifying Activities.

July-September 2018

- The first Consumer Advisory Board meeting representing the CCN network meets in July/August to develop bylaws, guidelines, and to elect officers.
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Monthly Member Status Reports completed. Submit record of all Qualifying Activities.
- Participate in feedback sessions with selected Care Management software vender to provide input for software enhancements.

The Consumer Advisory Board will meet quarterly after the initial meeting.

October-December 2018

- CAB provides an Annual Report for Executive Committee in December.
- Budget Report and Narrative submitted for approval. DSRIP Participation Plan submitted for approval.
- Monthly Member Status Reports completed. Submit record of all Qualifying Activities.
- Additional staff recruited and trained to accommodate new Enrollees. 120.74 FTEs of staff hired by December 31, 2018 to support 4,135 Enrollees in Budget Period Two.
- Annual Report with CAB input is submitted to EOHHS by October 31, 2018.
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Additional furniture, equipment, office supplies, and program supplies purchased to support increase in staff and Engaged Enrollees.
- Quality Measures Report completed by Quality Management Committee and reviewed by the Executive Committee and Consumer Advisory Board.
- Quality Improvement Plan developed by Quality Management Committee and Performance Improvement Team incorporating feedback from the Member Engagement Survey. New quality measures developed as needed.

The following committees will meet monthly: Executive Committee, Quality Management Committee, Human Resources and Training Committee, and Network Operations Committee. The Consumer Advisory Board will meet quarterly.

Budget Period Two (January 1, 2019 - December 31, 2019)

January-March 2019

- Outreach and intake efforts continue, Qualifying Activities continue, and Enrollees declining services are disengaged throughout the quarter.
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Care Coordinator assigned within five business days. Care Plan completed for all Engaged Enrollees within 90 days of signing the Participation Form.
- Information about participating in the Consumer Advisory Board distributed to Enrollees.
- Monthly Member Status Report completed. Submit record of all Qualifying Activities.
- Renew contractual agreements with MCOs and ACOs.
- Staff complete annual fresher training corresponding to their hire date.

April-June 2019

- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Monthly Member Status Reports completed. Submit record of all Qualifying Activities.
- Staff complete annual refresher training corresponding to their hire date.

July-September 2019

- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Monthly Member Status Reports completed. Submit record of all Qualifying Activities.
- Participate in feedback sessions with selected Care Management software vender to provide input for software enhancements.

- Semi-Annual Report is submitted to EOHHS in July.
- Staff complete annual refresher training corresponding to their hire date.

October-December 2019
- CAB provides an Annual Report for the Executive Committee in December.
- Budget Report and Narrative submitted for approval. DSRIP Participation Plan submitted for approval.
- Monthly Member Status Reports completed. Submit record of all Qualifying Activities.
- Additional staff recruited and trained to accommodate new Enrollees. 162.21 FTEs of staff hired by December 31, 2019 to support 5,555 Enrollees in Budget Period Three.
- Annual Report with CAB input is submitted to EOHHS by October 31, 2019.
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Additional furniture, equipment, office supplies and program supplies purchased to support increase in staff and Engaged Enrollees.
- Quality Measures Report completed by Quality Management Committee and reviewed by the Executive Committee and Consumer Advisory Board.
- Quality Improvement Plan developed incorporating feedback from the Member Engagement Survey. New quality measures developed as needed.
- Staff complete annual refresher training corresponding to their hire date.

The following committees will meet monthly: Executive Committee, Quality Management Committee, Human Resources and Training Committee, and Network Operations Committee. The Consumer Advisory Board will meet quarterly.

Budget Period Three (January 1, 2020 - December 31, 2020)

January-March 2020
- Outreach and intake efforts continue, Qualifying Activities continue, and Enrollees declining services are disengaged throughout the quarter.
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Care Coordinator assigned within five business days. Care Plan completed for all Engaged Enrollees within 90 days of signing the Participation Form.
- Information about participating in the Consumer Advisory Board distributed to Enrollees.
- Monthly Member Status Report completed. Submit record of all Qualifying Activities.
- Renew contractual agreements with MCOs and ACOs.
- Staff complete annual fresher training corresponding to their hire date.

April-June 2020
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Monthly Member Status Reports completed. Submit record of all Qualifying Activities.
- Staff complete annual refresher training corresponding to their hire date.

July-September 2020
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Monthly Member Status Reports completed. Submit record of all Qualifying Activities.

- Participate in feedback sessions with selected Care Management software vender to provide input for software enhancements.
- Semi-Annual Report is submitted to EOHHS in July.
- Staff complete annual refresher training corresponding to their hire date.
- Quality Measures analyzed for implications of pay for performance. Executive Committee develops response to mitigate financial risk.

October-December 2020
- Consumer Advisory Board provides an Annual Report for the Executive Committee in December.
- Budget Report and Narrative submitted for approval. DSRIP Participation Plan submitted for approval.
- Monthly Member Status Reports completed. Submit record of all Qualifying Activities.
- Additional staff recruited and trained to accommodate new Enrollees. 210.97 FTEs of staff hired by December 31, 2020 to support 7,225 Enrollees in Budget Period Four.
- Annual Report with CAB input is submitted to EOHHS by October 31, 2020.
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Additional furniture, equipment, office supplies and program supplies purchased to support increase in staff and Engaged Enrollees.
- Quality Measures Report completed by Quality Management Committee and reviewed by the Executive Committee and Consumer Advisory Board.
- Quality Improvement Plan developed incorporating feedback from the Member Engagement Survey. New quality measures developed as needed.
- Staff complete annual refresher training corresponding to their hire date.

The following committees will meet monthly: Executive Committee, Quality Management Committee, Human Resources and Training Committee, and Network Operations Committee. The Consumer Advisory Board will meet quarterly.

Budget Period Four (January 1, 2021 - December 31, 2021)

January-March 2021
- Outreach and intake efforts continue, Qualifying Activities continue, and Enrollees declining services are disengaged throughout the quarter.
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Care Coordinator assigned within five business days. Care Plan completed for all Engaged Enrollees within 90 days of signing the Participation Form.
- Information about participating in the Consumer Advisory Board distributed to Enrollees.
- Monthly Member Status Report completed. Submit record of all Qualifying Activities.
- Renew contractual agreements with MCOs and ACOs.
- Staff complete annual fresher training corresponding to their hire date.

April-June 2021
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Monthly Member Status Reports completed. Submit record of all Qualifying Activities.

- Staff complete annual refresher training corresponding to their hire date.

July-September 2021
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Monthly Member Status Reports completed. Submit record of all Qualifying Activities.
- Participate in feedback sessions with selected Care Management software vender to provide input for software enhancements.
- Semi-Annual Report is submitted to EOHHS in July.
- Staff complete annual refresher training corresponding to their hire date.
- Quality Measures analyzed for implications of pay for performance. Executive Committee develops response to mitigate financial risk.

October-December 2021
- Consumer Advisory Board provides an Annual Report for the Executive Committee in December.
- Budget Report and Narrative submitted for approval. DSRIP Participation Plan submitted for approval.
- Monthly Member Status Reports completed. Submit record of all Qualifying Activities.
- Additional staff recruited and trained to accommodate new Enrollees. 254.62 FTEs of staff hired by December 31, 2020 to support 8,720 Enrollees in Budget Period Five.
- Annual Report with CAB input is submitted to EOHHS by October 31, 2021.
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Additional furniture, equipment, office supplies and program supplies purchased to support increase in staff and Engaged Enrollees.
- Quality Measures Report completed by Quality Management Committee and reviewed by the Executive Committee and Consumer Advisory Board.
- Quality Improvement Plan developed incorporating feedback from the Member Engagement Survey. New quality measures developed as needed.
- Staff complete annual refresher training corresponding to their hire date.

The following committees will meet monthly: Executive Committee, Quality Management Committee, Human Resources and Training Committee, and Network Operations Committee. The Consumer Advisory Board will meet quarterly.

Budget Period Five (January 1, 2022 - December 31, 2022)

January-March 2022
- Outreach and intake efforts continue, Qualifying Activities continue, and Enrollees declining services are disengaged throughout the quarter.
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Care Coordinator assigned within five business days. Care Plan completed for all Engaged Enrollees within 90 days of signing the Participation Form.
- Information about participating in the Consumer Advisory Board distributed to Enrollees.
- Monthly Member Status Report completed. Submit record of all Qualifying Activities.
- Renew contractual agreements with MCOs and ACOs.

- Staff complete annual fresher training corresponding to their hire date.

April-June 2022
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Monthly Member Status Reports completed. Submit record of all Qualifying Activities.
- Staff complete annual refresher training corresponding to their hire date.
-

July-September 2022
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Monthly Member Status Reports completed. Submit record of all Qualifying Activities.
- Participate in feedback sessions with selected Care Management software vender to provide input for software enhancements.
- Semi-Annual Report is submitted to EOHHS in July.
- Staff complete annual refresher training corresponding to their hire date.
- Quality Measures analyzed for implications of pay for performance. Executive Committee develops response to mitigate financial risk.

October-December 2022
- Consumer Advisory Board provides an Annual Report for the Executive Committee in December.
- Budget Report and Narrative submitted for approval.
- Sustainability Plan submitted for approval.
- Monthly Member Status Reports completed. Submit record of all Qualifying Activities.
- Annual Report with CAB input is submitted to EOHHS by October 31, 2022.
- Notify EOHHS/MCOs/ACOs monthly with capacity to accept new referrals.
- Quality Measures Report completed by Quality Management Committee and reviewed by the Executive Committee and Consumer Advisory Board.
- Quality Improvement Plan developed incorporating feedback from the Member Engagement Survey. New quality measures developed as needed.
- Staff complete annual refresher training corresponding to their hire date.

The following committees will continue to meet monthly: Executive Committee, Quality Management Committee, Human Resources and Training Committee, and Network Operations. The Consumer Advisory Board will meet quarterly.

7.3 G Budget Report and Budget Narrative

7.3 G Budget Report and Budget Narrative - See Attachments B and C.

7.3 H Sustainability

7.3 H Sustainability (2 pages)

CCN took the issue of sustainability into consideration in the preparation of its program budget and infrastructure budget for the Behavioral Health Community Partner Initiative.

Business Start-up Costs
CCN expects to spend 49% of its infrastructure and capacity-building budget on business start-up costs, which are comprised of one week's salary during the Preparation Budget Period (PBP), anticipated revenue gaps in Years 1-3, and office equipment and furniture in PBP and Year 1.

Revenue Gaps
The CCN revenue for budget Periods 1-3 reflects a projection of Enrollee numbers that is slightly lower than the capacity that we would be able to serve with the number of FTEs built into budgeted salaries. The CCN Enrollee capacity (based on budgeted FTEs) is actually 18.5% higher than the projected Enrollees in Year 1, 12.5% higher in Year 2, and 7.25% higher in Year 3. The reason CCN has built in this gap between Enrollee capacity and projected number of Enrollees over this 3-year period is to allow for the expectation that, during this time, we may not be able to successfully engage all Enrollees as the BHCP model is developed and refined.

With respect to Years 4 and 5, CCN expects to incur losses but is working on developing strategies with EOHHS and our partners to mitigate projected losses.

Technology
CCN expects to spend 18% of its infrastructure and capacity-building budget on technology costs, which are comprised of interface development, care management software, website development, and purchase of computers. The two largest technology expenses are $270,000 for developing interfaces with each ACO and $200,000 for the initial investment in Years 1 and 2 for care management software. In the future, we believe that subsequent technology investments can be absorbed in program expenses, specifically the supply line item, which anticipates ongoing non-capital purchases.

Operational Infrastructure
CCN expects to spend 21% of its infrastructure and capacity-building budget on operational infrastructure, which is comprised of salaries and fringe for a Quality Data Analyst and a Program Function Manager. In the future, we believe these salaries can be absorbed in program expenses.

Workforce Development
CCN expects to spend 6% of its infrastructure and capacity-building budget on workforce development. The major component of this category is the salary plus fringe for an HR recruiter. In the future, we believe this salary can be absorbed in program expenses.

Summation
In summary, CCN will collectively be exploring alternative payment arrangements with both the ACOs and the MCOs as a strategy for long-term sustainability of the Community Behavioral Health Partner Initiative. Due to CCN's comprehensive continuum of care, we believe we are

well positioned to contract for episode of care payments for Enrollees with both mental health and substance use disorders.

7.3 I Quality Management and Performance Monitoring

7.3 I Quality Management and Performance Monitoring (3 pages)

1. Description of the Quality Improvement Program: The CCN is committed to achieving excellence in our coordination and delivery of services, including Enrollee satisfaction and outcomes of the BHCP. In order to accomplish this, we are committed to a comprehensive model of quality management and performance monitoring. All network members have long-established outstanding Quality Assurance/Improvement models. This initiative has afforded us the opportunity to bring together our models, strategies, and lessons learned to develop an advanced, comprehensive, effective, and proven Quality Management Program.

The CCN partners have all utilized some variation of a Continuous Quality Improvement Model (CQI) to assess, monitor, and improve our systems, services, and outcomes. We have adopted the "Quality First" strategy. Although we are not ascribing to one particular theorist in the quality management field, much of our thinking is based on the leaders in the field, including Deming, Juran, Drucker, and Crosby.

We have integrated Deming's 14 points as a guideline for establishing our CQI program. Key to our CQI process is the Plan, Do, Check, Act Cycle (PDCA). By implementing the PDCA process, we study the problem by collecting data, strategize as a team on solutions, implement the intervention, and, most importantly, check to be sure the problem truly is being addressed. In order to respond in "real time," CCN partners plan to implement the Rapid Cycle PDCA. This model strongly encourages full participation of our staff, supervisors, Enrollees, and funding sources to provide feedback and immediately address feedback received through the Rapid Cycle process. We firmly believe that without employee "buy-in," the CQI process is something that others do, and the investment of staff is limited. To truly be an effective CQI program, everyone involved must "own" and take responsibility for the quality of the services.

To achieve this, both our Quality Management Team (QMT) and Performance Improvement Team (PIT) will be comprised of a diverse set of individuals with varying points of view and experience. Management and support staff, care coordinators, Enrollees, and funding sources will all have input to ensure fidelity to the model. The focus of CQI will be on education and training, not blaming, with recognition that quality is not the job of one person, but rather belongs to all.

Obtaining and analyzing data from multiple data sets is critical to the CQI model. Data for the CQI model will be collected in the following way:

Care Management Data Collection Points: The Care Management Software (eCMS) will be utilized to gather and report on the following items: date from contact to engagement, completion of assessment, date of first Care Team meeting, number of participants at the Care Team meeting, number of contacts per month, type of contact and any adverse events including, but not limited to hospitalization, relapse, complaint, or grievance. In addition, the eCMS will be designed with input from EOHHS and the ACO/MCO to include data points for the assessment of the Enrollees: Quality of Life, Chronic Disease Management, Caregiver Stress, Community Tenure, Isolation, Social Connectedness, Care Coordination and Care Management, and Care Transitions.

Documentation Reviews: Each CCN partner will be responsible for thorough and regular audits of its records for programmatic compliance, service, and quality of documentation. These record reviews will be standardized throughout the network, and reviews will be completed in the eCMS. The QMT will meet monthly to review the quantitative data and surveys. Reports will be provided to the Governance Executive Board.

Enrollee Satisfaction Surveys: These surveys administered at least annually will assess the Enrollee's self-report on his/her progress towards his or her identified goals and overall satisfaction with care coordination.

Staff Satisfaction Surveys: These surveys will assess staff satisfaction with the training and resources available to perform their duties and confidence in their skills and tools provided. This measure allows us to assess stability in the workforce and implement strategies for retention.

Incident Reporting: Critical incident reports are completed by staff and reviewed by the Quality Management Team. Depending on the incident severity, the incident may require a review/investigation that is conducted by the Director of Quality or equivalent by each CCN partner. Results from the review/investigation are shared with the appropriate personnel and reported to the Governance Executive Board, as needed.

2. A description of at least one quality initiative Bidder proposes to undertake in Budget Period 1 including measures for success.

The term "transition of care" connotes a dynamic process by which an Enrollee moves from one care setting to another, such as hospital to home, skilled nursing or rehab facility, or detox to a less restrictive/residential setting. It can also describe transitions from one provider to another, such as changes in primary or specialty care or behavioral health provider. Care transitions frequently involve multiple persons, including the Enrollee, family, or caregivers, nurses, social workers, case managers, pharmacists, physicians and others. "An optimal transition should be well planned and adequately timed. Research has shown that communication between settings or providers often fails to supply all the information needed for optimum care."[6] According to a study on Innovations in Care Transitions, "fragmentation of health care services can adversely affect care experiences and outcomes while increasing costs of care. Effective Care Coordination and transitions can help to integrate care and prevent poor outcomes that give rise to avoidable hospitalizations and readmissions." [7]

With this in mind, CCN will focus its first-year quality initiative on transitions in care. We expect those enrolled to experience several transitions in a year. Our approach in providing effective care coordination is to facilitate smooth transitions that involve timely and complete information exchange between those involved, participation in the transition planning process from the outset, and assisting the Enrollee and those providing care/support through and after transition to fully understand next steps and necessary follow-up.

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[6] Improving Transitions of Care: Hospital to Home; National Transitions of Care Coalition; 2009

[7] The Commonwealth Fund; Gaining Ground: Care Management Programs to Reduce Hospital Admission and Readmission Among Chronically Ill and Vulnerable patients; 2013

Quality Initiative Year 1:

Quality Goal	Methodology /Data	Outcome/Measure of Success
To coordinate effective care transitions that reduce avoidable readmission and/or increases in level of care	Comprehensive assessment/baseline data on number of care transitions in the year prior to enrollment Transition checklist to guide Care Coordinator involvement/activities through the transition process. Dates of admission; discharge; diagnosis & follow up documented; checklist completion; year over year comparative analysis	10% reduction in number of Enrollee hospitalizations/increases in level of care and/or Reduction in number of days in higher level of care 75% Care Transition checklist utilization

3. Function of Bidder's Quality Committee, including composition and reporting structure within the Bidder's organization

The CCN will have the following quality structure in order to support the robust CQI program.

Governance Executive Board: Comprised of the Executive Directors/Chief Executive Officers of the CCN collaboration. The governing body is responsible for reviewing and submitting the annual QM plan to EOHHS for approval. The governing body will meet quarterly, and more frequently if needed, to ensure the quality of the service.

Quality Management Team (QMT): Comprised of the CCN partners' senior level quality management staff. Will be responsible for overseeing the implementation of the CQI program. The QMT will meet monthly to establish compliance and quality standards, oversee training, establish Performance Improvement Teams, and report and submit recommendations to the Governance Executive Board on a regular basis.

Performance Improvement Teams (PIT): These teams are critical to the CQI program and will be developed by the Quality Management Team (QMT). In order to be true to the model of involvement at all levels, the following are the teams that will be proposed: Care Coordination Implementation Team, Human Rights Team, Best Practices Team, Satisfaction Team, Multi-Disciplinary Team, and Information Technology Team. PIT will report to the QMT.

7.3 J Coordination with MCOs and ACOs

7.3 J Coordination with MCOs and ACOs (2 pages)

The success of this initiative will require positive, respectful, and collaborative working relationships between the BHCP and the ACO/MCOs. We will be learning together how best to implement, monitor, initiate, and adjust our systems, so that Enrollees receive the quality services they deserve. The Coordinated Care Network's (CCN) six Affiliated Partners and three Material Subcontractors all have long histories of multiple complementary relationships with health care systems, state agencies, and Managed Care Organizations (MCOs). This extensive experience has laid the foundation for CCN to work successfully and collaboratively in complex systems.

1. How Bidder will communicate its skills, expertise, and value to potential ACOs/ MCOs

CCN is confident that our comprehensive skills will provide significant value to the ACO/MCO. As a Network, we collectively offer considerable years of expertise in working with children, youth, adults and families; substance use, mental health, and co-occurring disorders; homeless individuals and families; intellectual/developmental disabilities and brain injuries; and other complex medical needs.

Our wide breadth of services across a diverse population will be clearly articulated to the ACO/MCO staff. We will provide a comprehensive listing of all services being offered and will continually apprise the ACO/MCO staff of any service additions or revisions. We will use both our website and e-mail notifications to ensure the ACO/MCO always has the most up-to-date information and resources.

2. Branding and Marketing plans Bidder has respect to the relationship with ACOs/MCOs.

In order to ensure that the CCN is widely recognized as a valuable resource to our communities, we will develop and maintain an informative and user-friendly website. The website will primarily provide information regarding the CCN BHCP Care Coordination program. In addition, MCOs/ACOs will be invited to share their information on the CCN website. The website will include resources available by CCN partner organizations in each MassHealth service area.

Marketing brochures will be developed, in partnership with the ACO/MCO, in two formats. One will provide outreach and educational information to encourage Enrollees' participation in programs. The other will be used to publicize and educate the ACO/MCOs and their staff regarding our network capacity. CCN will distribute marketing brochures to the primary care practices associated with our ACO/MCO partners. Moreover, we will make personal visits to the primary care practice offices to open a dialogue regarding this new initiative and answer questions. The CCN is committed to developing a quarterly newsletter and an Annual Report, which will be distributed to Enrollees, MassHealth, ACOs, MCOs, and the community as a whole to highlight the CCN's valuable work.

CCN partners will invite our MCO/ACO partners to participate in health fairs and community events. CCN is an active member of the United Way in all of the service areas we propose to serve. United Way partners and volunteer community events are another venue where we will educate the health systems and their employees about the diverse services CCN provides in the community. In addition, CCN's partners are active participants on many community boards and coalitions (including those concerning local and regional homeless communities), public health local, Rotaries, Chambers of Commerce and regional planning committees, as well as DPH BSAS and DMH regional meetings in all areas we are proposing to serve.

3. Bidder's strategy to engage and collaborate with multiple ACO/MCO in service area.
Upon reviewing the EOHHS list of request for responses for the Accountable Care Organizations' intent to bid document, we have identified existing relationships between agencies in our Network and every potential bidder in our proposed service areas.
Currently, CCN partners have worked with MassHealth members from all six of the previously selected pilot ACOs, providing them with a full continuum of behavioral health services, including crisis evaluations, psychiatric hospitalization, acute detoxification, crisis stabilization, dual diagnosis services, clinical stabilization services, outpatient mental health and SUD treatment, case management services, and residential services. These existing relationships will build the foundation for ongoing engagement and collaboration.

Our strategy to engage and collaborate with multiple ACOs/MCOs in our proposed service areas will be built upon these existing relationships and continue to strengthen them. Our intent will be for the CCN CEOs to personally meet with the management team of each ACO/MCO in our areas to provide them with a comprehensive presentation of the extraordinary depth of our expertise and comprehensive continuum of care. In addition, we will take time to fully understand the needs of the ACOs/MCOs, so we can work with them to meet these needs. To ensure we meet the expectations of the ACOs/MCOs, it is our intent to set quality and performance goals, which will be reported on an ongoing basis. We also plan to extend invitations to all ACO/MCO staff to participate in our training programs. This will not only build a universal fund of knowledge, but nurture these relationships.

Our CCN has over 200 physical locations spread throughout the 11 service areas we are proposing to serve. We are not only a physical presence in the communities where we reside and work, but also an integral part of the safety net for countless MassHealth members- the same MassHealth members who will be the primary population served by the BHCP Initiative.

When working with the operating ACO health systems, CCN will offer the option of embedding behavioral health services from a CCN's partner into their primary care practice.

4. Bidder's strategy for conflict resolution should conflicts arise between Bidder and MCO/ACO
With such a large and expansive initiative, conflicts will likely arise. Our premise is to work with the ACO/MCO in an open, respectful, and supportive manner. We are committed to addressing conflicts immediately to maintain positive and productive relationships with both our partners and our Enrollees. Our strategy for conflict resolution begins with working together to collect and review relevant information and outlining solutions that will bring about a positive resolution for all parties involved. Our experience has been that a non-confrontational approach works best. Providing support for the involved individuals/groups to work things through together not only develops goodwill, but encourages ongoing conflict resolution. We recognize that this approach is not always possible, so our Quality Management and Executive Teams will be brought in as well when appropriate.

Community Partner Program Budget Report

Innovative Care Partners, LLC.

Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Estimated Enrollees- Start of Period (All Enrollees)		500	1,500	2,300	3,200	4,000	
Estimated Enrollees - End of Period (All Enrollees)		1,500	2,300	3,200	4,000	4,000	
Estimated Enrollees - Monthly Average (excl CBFS enrollees)		732	1,590	2,300	3,175	3,550	
Estimated Enrollees - Monthly Average (CBFS enrollees only)		225	300	400	425	450	
Estimated Program Revenue (excl CBFS enrollees)		$ 922,320	$ 3,434,400	$ 4,968,000	$ 6,858,000	$ 7,668,000	$ 23,850,720
Estimated Program Revenue (CBFS enrollees only)		$ 393,750	$ 900,000	$ 1,200,000	$ 1,275,000	$ 1,350,000	$ 5,118,750
Total Estimated Program Revenue		**$ 1,316,070**	**$ 4,334,400**	**$ 6,168,000**	**$ 8,133,000**	**$ 9,018,000**	**$ 28,969,470**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -	$ -	$ -	$ -
Revenue for Operations		**$ 1,316,070**	**$ 4,334,400**	**$ 6,168,000**	**$ 8,133,000**	**$ 9,018,000**	**$ 28,969,470**

	Program Expenses		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
1	**Salary**		$ 177,917	$ 948,538	$ 2,596,515	$ 3,450,243	$ 4,447,280	$ 4,754,240	$ 16,374,733
2	**Fringe**		$ 42,597	$ 242,536	$ 711,540	$ 959,979	$ 1,184,634	$ 1,196,512	$ 4,337,798
	Total Personnel Costs		$ 220,514	$ 1,191,074	$ 3,308,055	$ 4,410,222	$ 5,631,914	$ 5,950,752	$ 20,712,531
3	**Training & Professional Development**		$ -	$ 50,000	$ -	$ -	$ 50,000	$ 50,000	$ 150,000
4	**Travel**		$ -	$ 63,533	$ 173,300	$ 245,700	$ 327,600	$ 363,300	$ 1,173,433
5	**Equipment**		$ 1,260	$ 14,700	$ 37,800	$ 57,800	$ 25,200	$ 25,200	$ 161,960
6	**Supplies**		$ 1,500	$ 103,000	$ 123,000	$ 175,000	$ 201,000	$ 170,500	$ 774,000
7	**Contract Services** (consulting, professional)		$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	**Software licensing**			$ 31,500	$ 68,040	$ 97,200	$ 129,600	$ 144,000	$ 470,340
9	**Telecommunications**		$ 3,420	$ 36,100	$ 82,800	$ 107,600	$ 82,800	$ 102,000	$ 414,720
10	**Occupancy** (rent, utilities, maintenance)		$ 20,250	$ 90,750	$ 135,000	$ 160,000	$ 135,000	$ 154,050	$ 695,050
11	**Other**		$ -	$ 2,000	$ 2,000	$ 5,000	$ 6,500	$ 6,500	$ 22,000
	Total Direct Costs		$ 246,944	$ 1,582,657	$ 3,929,995	$ 5,258,522	$ 6,589,614	$ 6,966,302	$ 24,574,034
12	**Indirect Cost/Administrative Overhead**	**11.0%**	**$ 27,164**	**$ 174,092**	**$ 432,299**	**$ 578,437**	**$ 724,858**	**$ 766,293**	$ 2,703,144
	TOTAL EXPENSES		$ 274,108	$ 1,756,749	$ 4,362,294	$ 5,836,959	$ 7,314,472	$ 7,732,595	$ 27,277,178
	Surplus/Shortfall		*$ (274,108)*	*$ (440,679)*	*$ (27,894)*	*$ 331,041*	*$ 818,528*	*$ 1,285,405*	*$ 1,692,292*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Director	$ 140,000.00	0.6	5	$ 35,000
Assistant Directors	$ 80,000.00	2.5	3	$ 50,000
Clinical Care Mgr (RN)	$ 75,000.00	3	1	$ 18,750
Clinical Care Coordinators	$ 38,000.00	10	1.5	$ 47,500
Enrollment Manager	$ 60,000.00	0.6	4	$ 12,000
Enrollment Specialist	$ 34,000.00	2	1	$ 5,667
Administrative Assistant	$ 30,000.00	0.6	6	$ 9,000
				$ -
				$ -
Total Salary (Program Budget Line 1)		**19.3**		**$ 177,917**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 177,917	24%	$ 42,597
Total Fringe (Program Budget Line 2)			**$ 42,597**

Total Personnel*	**$ 220,513**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

-The Director provides overall management of BH CP program;
-Assistant Directors provide management oversight of one service hub and Care Coordination teams; they also supervise Clinical Care Managers
-Clinical Care Managers (RN) supervise Care Coordinators assigned to CC Team; review and sign off on Enrollee Treatment Plans and conduct medication reconciliation.
-Clinical Care Coordinators conduct assessments, and perform care planning and care coordination services for Assigned and Engaged Enrollees.
-Enrollment Manager designs enrollment plan, manages department, supervises Enrollment Specialists, conducts outreach; provides liaison function with ACOs and MCOs.
-Enrollment Specialist conducts enrollee intake, including outreach to Assigned Enrollees, and assigns enrollees to appropriate Service hub.
-Administrative Assistant provides administrative support to Program Director and is responsible for

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
			$ -
Total Training and Professional Development (Program Budget Line 3)			

Provide a description of each Training and Professional Development line item included in the table above:

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
			Total Mileage	$ -

Travel Expense Description	Cost
Total Mileage	$ -
Parking and tolls	
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ -**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

Row 5 - Equipment

Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost
Copier rentals - monthly fee	210	6	$ 1,260.00
Total Equipment (Program Budget Line 5)			**$ 1,260.00**

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Copy machines for offices occupied by CP staff; intended use includes copying clinical and administrative data for files as well as printing documents from computers. Expected rental costs are for one month in the prep period, with two copiers per office (total of 3 offices expected for covered regions) Costs is based on existing provider experience and is apportioned to reflect 60% allocation to BH CP and 40% to LTSS CP, using typical monthly rental fee of $350 per unit.

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Start up office supplies			$ 1,500.00
Total Supplies (Program Budget Line 6)			**$ 1,500.00**

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined

Routine general office materials to be used in normal course of administration. Estimate is pursuant to provider experience and assumed adequate levels for anticipated prep period staff.

During the Prep period, it is expected that approximately 12 FTEs (non-duplilcated with LTSS) of the overall staffing which is coming in over the 7 month period will require approximately $125 per FTE.

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
Total Software Licensing			

(Program Budget Line 8)	

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Land lines for 3 sites for 3 months; assume $300 per month/per site, apportioned as 60% for BH CP; remaining 40% is LTSS CP	300	3	$ 1,620.00
Internet data lines for 3 months for 3 sites; assumed $200 cost per site using current experience;	200	3	$ 1,800.00
Total Telecommunications (Program Budget Line 9)			**$ 3,420.00**

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Land lines will support desk-top activity for communication with clients and other constituents, complimenting availability of cellular communication. Internet data lines are essential for routine communication as well as for web-based access to EHR software.

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent	9000	15	$ 20,250.00
Utilities			$ -
Repair and Maintenance			$ -
			$ -
			$ -
Total Occupancy (Program Budget Line 10)			**$ 20,250.00**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

Provider will require 3 regional offices in service areas at 3K square feet each for ultimate staffing levels. Rent would begin 3 months prior to 6/1 start of services to support hiring, staffing, training and general program start-up. Rental rate is presumed at $15 inclusive of utilities, housekeeping and common area management. No repairs and maintenance are expected in prep period (general CAM is included in $15/psf rate). Note: costs are allocated 60% to BH CP and 40% to LTSS CP in prep period only. Thereafter, BH CP absorbs full space for commun use with LTSS CP, given financial inability for LTSS funds to share in allocation.

At maximum staffing levels, 140 individuals between LTSS and BH will be employed, office space for which will be provided in regional locations. While all staff are not expeccted to be at each office 100% of their time and many staff can share space (rather than dedicated cubicle/office per person), 9,000 sq feet is based on general allocation of approximately 60 sq feet per work station/area, plus common space such as conference rooms.

Row 11 - Other

Other Direct Expense Description	Cost
Total Other (Program Budget Line 11)	

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	**11.00%**	**$ 27,164.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Administrative overhead required to effectively execute and coordinate the business functions of the community partner services is inclusive of following support services:

A) Finance administration
B) HR management
C) Qualitative performance measurement & reporting
D) Tax and cost report compliance
E) Third party billing and contract management

The 11% rate reflects historical experience of Innovative Care Partner's managing partner (CHD). CHD's current federal allowable indirect rate is 11.7%.

Added note pursuant to assistance/guidance from contract manager:

Certain costs could not be deferred to the following budget year. Therefore, in order to maintain spending within the $450K available, downward cost adjustments were necessary as well as allocations to the LTSS budget. These include reduced spending desired for training, recruitment activities and supplies.

Community Partner Infrastructure Budget Report

		Innovative Care Partners, LLC						
	Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
	PMPM Infrastructure Rate		$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
	Engaged Enrollees		1,500	1,500	2,300	3,200	4,000	
	Estimated Infrastructure Funds		$ 1,050,000	$ 1,548,900	$ 1,421,124	$ 1,743,360	$ 1,885,440	**$ 7,648,824**
	At- Risk Withhold Rate			25%	44%	63%	81%	
	Withhold			$ 387,225	$ 625,295	$ 1,098,317	$ 1,527,206	**$ 3,638,043**
	TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 1,050,000	$ 1,161,675	$ 795,829	$ 645,043	$ 358,234	**$ 4,460,781**

	Infrastructure Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
	Technology								
1	**IT Staffing including Fringe**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
2	**Development Adaptation of EHR and/or Care Management System**		$ 76,000	$ -	$ -	$ -	$ -	$ -	**$ 76,000**
3	**Technology for Service Delivery**		$ 14,000	$ 100,000	$ 50,000	$ -	$ -	$ -	**$ 164,000**
4	**Other Technology Expenses**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Technology		$ 90,000	$ 100,000	$ 50,000	$ -	$ -	$ -	**$ 240,000**
	Workforce Development								
5	**Workforce Development staffing including Fringe**		$ 20,015	$ 25,930	$ 45,341	$ 45,341	$ 45,463	$ 45,463	**$ 227,553**
6	**Recruitment Expenses**		$ 12,000	$ 75,000	$ 75,000	$ 75,000	$ 75,000	$ 75,000	**$ 387,000**
7	**Training Expenses**		$ -	$ 50,000	$ 100,000	$ 125,000	$ 75,000	$ 60,000	**$ 410,000**
8	**Retention Expenses**		$ -	$ -	$ -	$ 50,000	$ 50,000	$ 70,000	**$ 170,000**
	Total Workforce Development		$ 32,015	$ 150,930	$ 220,341	$ 295,341	$ 245,463	$ 250,463	**$ 1,194,553**
	Business Start Up Costs								
9	**Office Equipment (PBP & BP1 only)**		$ -						**$ -**
10	**Office Furniture (PBP & BP1 only)**		$ -	$ 100,000					**$ 100,000**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**		$ 274,108	$ 440,679	$ 27,894	$ -			**$ 742,682**
	Total Business Start Up Costs		$ 274,108	$ 540,679	$ 27,894	$ -			**$ 842,682**
	Operational Infrastructure								
12	**Operation Staffing including Fringe**		$ 25,945	$ 50,420	$ 88,164	$ 88,164	$ 88,400	$ 88,400	**$ 429,493**
13	**Other Operational Expenses**		$ 10,000	$ 125,000	$ 125,000	$ 125,000	$ 125,000	$ 75,000	**$ 585,000**
	Total Operational Infrastructure		$ 35,945	$ 175,420	$ 213,164	$ 213,164	$ 213,400	$ 163,400	**$ 1,014,493**
14	**Indirect Cost/Administrative Overhead Rate**	11.0%	$ 17,376	$ 57,899	$ 53,186	$ 55,936	$ 50,475	$ 45,525	**$ 280,395**
	TOTAL INVESTMENTS		**$ 449,443**	**$ 1,024,928**	**$ 564,585**	**$ 564,441**	**$ 509,338**	**$ 459,388**	**$ 3,572,123**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary			$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Development of care management platform	$ 76,000.00

Total Development and Adaptation of EHR and Care Management System (Infrastructure Budget Line 2)	$ 76,000.00

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Development fee for care management platform to include configuration, ACO interoperability, billing and other CP specific platform initiatives. The total cost for development is allocated between BH CP and LTSS CP, for total of $200K. The allocation to BH CP is based on availability of funds within the $450K. A more specific allocation as based on antinipated utilization would be $120K to BH CP and $80K to LTSS CP.

For purposes of the Infrastructure Allocation, this cost is allocated fully to CHD as the services will be part of the general management of the CP. CHD is the managing member of ICP and has responsibility for coordinating general services including EHR.

Row 3 - Technology for Service Delivery

Description of Expense	Cost
Mobile technology devices; laptops	$ 14,000.00
Total Technology for Service Delivery	$ 14,000.00

(Infrastructure Budget Line 3)	$ 14,000.00

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Providing staff with laptop for performance of care coordination and electronic data recording. Prep period budget is sufficient to cover only $14K for staff hired during prep period. Expected costs are based on provider experience and vendor relationship for quantiity purchasing. It is estimated that individual set-ups of lap top and sufficient print devices will cost approximately $1K per individual. Investment in additional devices is delayed to BY 1

In the prep period, accomodations are being made for 14 individuals, building towards full capcity in later years. where FTEs will grow to 100. Number of staff persons exceeds 100 as it is expected that more than one person can comprise an FTE (as some individuals may be hired on part time basis). Total budget over prep and future budget periods is $164K to account for full staffing with laptops and print devices, as well as replacement of devices by BY 2.

The technology models/devicces expected are as follows. Several options/models have historically been used and are easily supported by our tecnolody departments. These are included herein as potential choices. Actual determination of which model is chosen (are chosen) will continue to be driven by availability and cost at time of purchase. Based on volume, ICP expects to leverage its purchasing power.

Type	Brand	Model
Laptop	Hewlett Packard	ProBook 400, 550, 850
Laptop	Hewlett Packard	EliteBook 8460P
Laptop	Lenovo	ThinkPad T530
Tablet	Microsoft	Surface Pro 4
Printer	Hewlett Packard	LaserJet, MFP, Color, BW
Printer/Copier	Canon	IR ADV 4545 I
Cell phones	Apple	iPhone 6s

Row 4 - Other Technology Expenses

Description of Expense	Cost

Total Other Technology Expenses (Infrastructure Budget Line 4)	

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Recruiter	$ 60,000.00	0.6	6	$ 18,000
				$ -
				$ -
				$ -
				$ -
				$ -

				$	-
				$	-
				$	-
	Total Salary	0.6		$	18,000
	Fringe rate	11.2%	Total Fringe	$	2,015
	Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)			**$**	**20,015**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

The recruiter is essential to implementing targeted activities intended to hire staff quickly and effectively. The recruiter is responsible for confirming roles, identifying core competencies and developing attractive, thoughtful job postings. Recruiter will use a number of online resources for advertising, including both broad-based and niche job boards.

For purposes of the Infrastructure Allocation, this position /cost is allocated fully to CHD as the position will be part of the general management of the CP. CHD is the managing member of ICP and has responsibility for coordinating general services including employment of such positions.

Row 6 - Recruitment Expenses

Description of Expense	Cost
Advertisements, job fair expenses, web-based postings, materials	$ 12,000.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 12,000.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Expensesd reflect routine activities and related costs based on provider experience as well as intentions to target certain markets and bilingual individuals. Costs are determined based on current experience and contracts for services (message boards, web services, newspapers). The total bnudget is broken down as follows:

Internet recruitment board (Indeed.com) $5K
Marketing Materials (professional informational brochures, billboards, general media) $3K
Job fairs & targeted recruitment - cost of venues and services (food/bevrages) & out of area travel $4K
For purposes of the Infrastructure Allocation, this cost is allocated 1/3 ($4,000) to each member of the consortium.

Row 7 - Training Expenses

Description of Expense	Cost
Total Training Expenses (Infrastructure Budget Line 7)	

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Row 8 - Retention Expenses

Description of Expense	Cost
Total Retention Expenses (Infrastructure Budget Line 8)	

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Business Start Up Costs - Prep Budget Period

Row 9 - Office Equipment

Description of Expense	Cost
Total Office Equipment (Infrastructure Budget Line 9)	

Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were determined:

Row 10 - Office Furniture

Description of Expense	Cost
Total Office Furniture (Infrastructure Budget Line 10)	

Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Quality Manager	$ 70,000.00	1	4	$ 23,333
				$ -

				$	-
				$	-
				$	-
				$	-
				$	-
				$	-
				$	-
	Total Salary	1		$	23,333
	Fringe rate	11.2%	Total Fringe	$	2,612
			Total Program Staffing including Fringe (Infrastructure Budget Line 12)	**$**	**25,945**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Quality Manager is responsible for creating and monitoring the QM plan; the manager will provide data and reports and staff the Quality Committee.

For purposes of the Infrastructure Allocation, this position /cost is allocated fully to CHD as the position will be part of the general management of the CP. CHD is the managing member of ICP and has responsibility for coordinating general services including employment of such positions.

Row 13 - Other Operational Expenses

Description of Expense	Cost
Professional business development advertisement	$ 10,000.00
Total Other Operational Expenses	**$ 10,000.00**

(Infrastructure Budget Line 13)	**$ 10,000.00**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Marketing material to educate clients, medical community, ACOs regarding CP services and ICP program. The full amount will be for professional material including brochures in various sizes and detail about the benefits of the CP program and how ICP can provide those services. It is anticipated that the brochures and material which will be mailed and otherwise distrubuted will cost $7K and media placement will cost $3K.

For purposes of the Infrastructure Allocation, this cost is allocated 1/3 ($3,333) to each member of the consortium.

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**11.00%**	**$ 17,376.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Administrative overhead required to effectively execute and coordinate the business functions of the community partner services

is inclusive of following support services:
A) Finance administration
B) HR management
C) Qualitative performance measurement & reporting
D) Tax and cost report compliance
E) Third party billing and contract management
The 11% rate reflects historical experience of Innovative Care Partner's managing partner (CHD). CHD's current federal allowable indirect rate is 11.7%.

Community Partner Infrastructure Allocation Worksheet

	Innovative Care Partners, LLC						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 1,050,000	$ 1,161,675	$ 795,829	$ 645,043	$ 358,234	$ 4,460,781
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Consortium Entity or Affiliated Partner - CHD	$ 80,666	$ 33,333	$ 16,667	$ -	$ -	$ -	$ 130,666
Consortium Entity or Affiliated Partner - ServiceNet	$ 4,667	$ 33,333	$ 16,667	$ -	$ -	$ -	$ 54,667
Consortium Entity or Affiliated Partner - Gandara	$ 4,667	$ 33,334	$ 16,666	$ -	$ -	$ -	$ 54,667
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ 90,000	$ 100,000	$ 50,000	$ -	$ -	$ -	$ 240,000
Workforce Development							
Consortium Entity or Affiliated Partner - CHD	$ 24,015	$ 67,597	$ 103,675	$ 128,675	$ 112,129	$ 113,796	$ 549,887
Consortium Entity or Affiliated Partner - ServiceNet	$ 4,000	$ 41,667	$ 58,333	$ 83,333	$ 66,667	$ 68,333	$ 322,333
Consortium Entity or Affiliated Partner - Gandara	$ 4,000	$ 41,666	$ 58,333	$ 83,333	$ 66,667	$ 68,334	$ 322,333
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ 32,015	$ 150,930	$ 220,341	$ 295,341	$ 245,463	$ 250,463	$ 1,194,553
Business Start Up Costs							
Consortium Entity or Affiliated Partner - CHD	$ 91,369	$ 180,226	$ 9,298	$ -	$ -	$ -	$ 280,894
Consortium Entity or Affiliated Partner - ServiceNet	$ 91,369	$ 180,226	$ 9,298	$ -	$ -	$ -	$ 280,894
Consortium Entity or Affiliated Partner - Gandara	$ 91,369	$ 180,226	$ 9,298	$ -	$ -	$ -	$ 280,894
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ 274,108	$ 540,679	$ 27,894	$ -	$ -	$ -	$ 842,681
Operational Infrastructure							
Consortium Entity or Affiliated Partner - CHD	$ 29,278	$ 92,086	$ 129,830	$ 129,831	$ 130,066	$ 113,400	$ 624,491
Consortium Entity or Affiliated Partner - ServiceNet	$ 3,334	$ 41,667	$ 41,667	$ 41,667	$ 41,667	$ 25,000	$ 195,002
Consortium Entity or Affiliated Partner - Gandara	$ 3,333	$ 41,667	$ 41,667	$ 41,666	$ 41,667	$ 25,000	$ 195,000
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ 35,945	$ 175,420	$ 213,164	$ 213,164	$ 213,400	$ 163,400	$ 1,014,493
TOTAL INVESTMENTS	$ 432,068	$ 967,029	$ 511,399	$ 508,505	$ 458,863	$ 413,863	$ 3,291,727

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	CC/CM Electronic Health Record Development	Fully operational CP-specific Electronic Record System	11/01/17	03/01/18	Testing completed	Successful testing			Electronic Health Record Training	Users are certified		
Technology	CP Reporting System	Initial set of performance and quality reports are developed and tested	01/01/18	03/01/18	Testing completed	Successful testing			Initial report set established	QM Committee Approval		
Technology												
Technology												
Workforce Development	CP Recruitment Strategy and Plan	Successful recruitment resulting in adequately staffed program at start-up	11/01/17	06/01/18	Management staff hired	Management staff hired			Staff hired per Prep Period Budget	Staff-enrollee ratio is met for projected 6/1/18 enrollment		
Workforce Development	CP Pre-Service Orientation and Training Program	Training Program is implemented at start up	01/01/18	05/01/18	Pre-Service Training Plan completed	Training plan approved by consortium entities			Initial staff are trained per plan	Training participation documentation		
Workforce Development												
Workforce Development												
Business Start Up Costs	CP Hub offices set up	Operational CP offices established to assure access in each Service Area	11/01/17	03/01/18	Minimum 4 offices to serve all Service Areas	Executed lease/rental agreements			Minimum 6 offices to serve all Service Areas	Executed leases/agreements; offices are fully equipped/operational		
Business Start Up Costs												
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Quality Management System	Performance and Quality Improvement (PQI) Plan is operational	01/01/18	05/01/18	PQI Plan completed	QM Committee established; PQI Plan approved			12-Month QM Monitoring and Review Calendar Completed	QM Committee Approval		
Operational Infrastructure												
Operational Infrastructure												
Operational Infrastructure												

BH Community Partner - Staffing Model

Innovative Care Partners. LLC

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	1,500	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	3.6	*Total management oversight of BH CP*
3	Medical Director		*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs		
5	Clinical Care Managers (RN)	5.2	*Do not include FTEs listed in line 4;*
6	Clinical Care Managers (LPHA)		*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders		*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff		*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	31	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)		*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists	2.6	*Includes Enrollment Manager and Enrollment Specialist*
12	Administrative Support	0.6	
13			
14			
	Total FTE	43	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1:288	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	1:6	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff:

The Clinical Care Managers will supervise Care Coordinators.

Section 7.3 Initial DSRIP Participation Plan

A. Executive Summary

1. Program Goals and Challenges: Innovative Care Partner's (ICP's) business plan for the five (5) year period of the BH CP contract reflect the following goals:

a. Supporting Enrollees with high behavioral health needs, i.e. individuals with serious mental illness (SMI) and/or serious substance use disorders (SUD);
b. Improving the care experience, continuity and quality of care for Enrollees by holistically engaging Enrollees in care coordination and care management activities;
c. Facilitating collaboration between ACOs and MCOs and BH community-based organizations to break down silos and promote integrated care so that the social determinants of health are more effectively addressed for members with high BH needs;
d. Working collaboratively with ACOs and MCOs to avoid duplication of care coordination and care management services for the population with high BH needs; and
e. Promoting and supporting the values of Community First, SAMHSA recovery principles, and cultural competence in providing care coordination and care management services to members with high BH needs.

ICP's business plan will incorporate strategies that address anticipated challenges, including, as examples, the following:

Potential Challenge	**Solutions/Strategies**
Enrollee Resistance to BH CP services	1. Effective matching of Enrollees to Care Coordinators in terms of language, cultural affinity, and experience with presenting Enrollee conditions 2. Enrollment Specialists and Care Coordinators trained in Motivational Interviewing (MI) 3. Collaboration with Enrollee's PCP, family members, and other care givers
Personnel Recruitment and Retention	1. Comprehensive staff recruitment plan including creative use of social media and other outreach avenues (See Section 7.3.E below) 2. Apply "Employer of Choice" strategies that have helped earn CHD "Best Non-profit Workplace" awards for the past two years
ACO and MCO Engagement	1. Leverage existing positive relationship of the Consortium Entities with each ACO and MCO 2. Establish collaboration processes, such as monthly Joint Operating Committee meetings, beginning in the Preparation Period (See Section 7.3.J. below)
Risk Sharing	1. Establish effective data analysis and reporting systems to allow timely monitoring of quality and financial measures 2. Maintain adequate cash and liquidity ratios
Technology	1. Devote adequate resources for information system software and hardware that meet contract requirements 2. Maintain active involvement with State and local planning groups working

	toward interoperability among entities and connection to Mass HIWay 3. Involve content experts within ICP's BH CP program with eHana design engineers to continuously improve the CC/CM platform during the Preparation Period and beyond

The Implementation Plan, in Section 7.3.F below, provides a list of business plan activities that will be accomplished in each contract year.

2. Proposed Number of Enrollees: ICP proposes to serve a caseload of ~~6,000~~4,000 Enrollees who reside within the seven Service Areas comprising the Western Region. It is expected that this target would be reached by the middle of Budget Year 2 (See Budget Narrative, Appendix B).

3. The **Service Areas** for which the ICP is bidding are Adams, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, and Westfield.

4. Operational Plan: A summary of significant components of the plan for operationalizing the BH CP program is provided below (For further details please also see Section 7.3.F-Implementation Plan):

November 2017 to ~~March~~ May 2018 – Preparation Period: (1) Hire Program Director by ~~November~~ December 1 and implement staff recruitment plan (See Section 7.3.E below); (2) Work with IS vendor (eHana) to complete customized Care Coordination/Care Management IS platform; (3) Finalize governance policies and procedures with Consortium Entities; (4) Equip Hub offices; (5) establish Quality Committee and Consumer Advisory Board; and (5) Conduct initial outreach meetings with ACOs and MCOs, execute Memorandum of Agreements, and establish referral and communication pathways and protocols.

~~April~~ June to December 2018 – Budget Period 1: (1) Continue to hire, train, and deploy CP personnel to meet member enrollment needs; (2) Implement program and quality data collection and reporting processes; (3) Maintain monthly joint operating meetings with ACOs and MCOs; and (4) Monitor Enrollee assignment process and Hub caseloads and adjust as needed.

Budget Periods 2-5: Continue to monitor all program and quality measures and adjust as needed.

Attachment D:Community Partners Service Area Coverage Form **(Revised)**

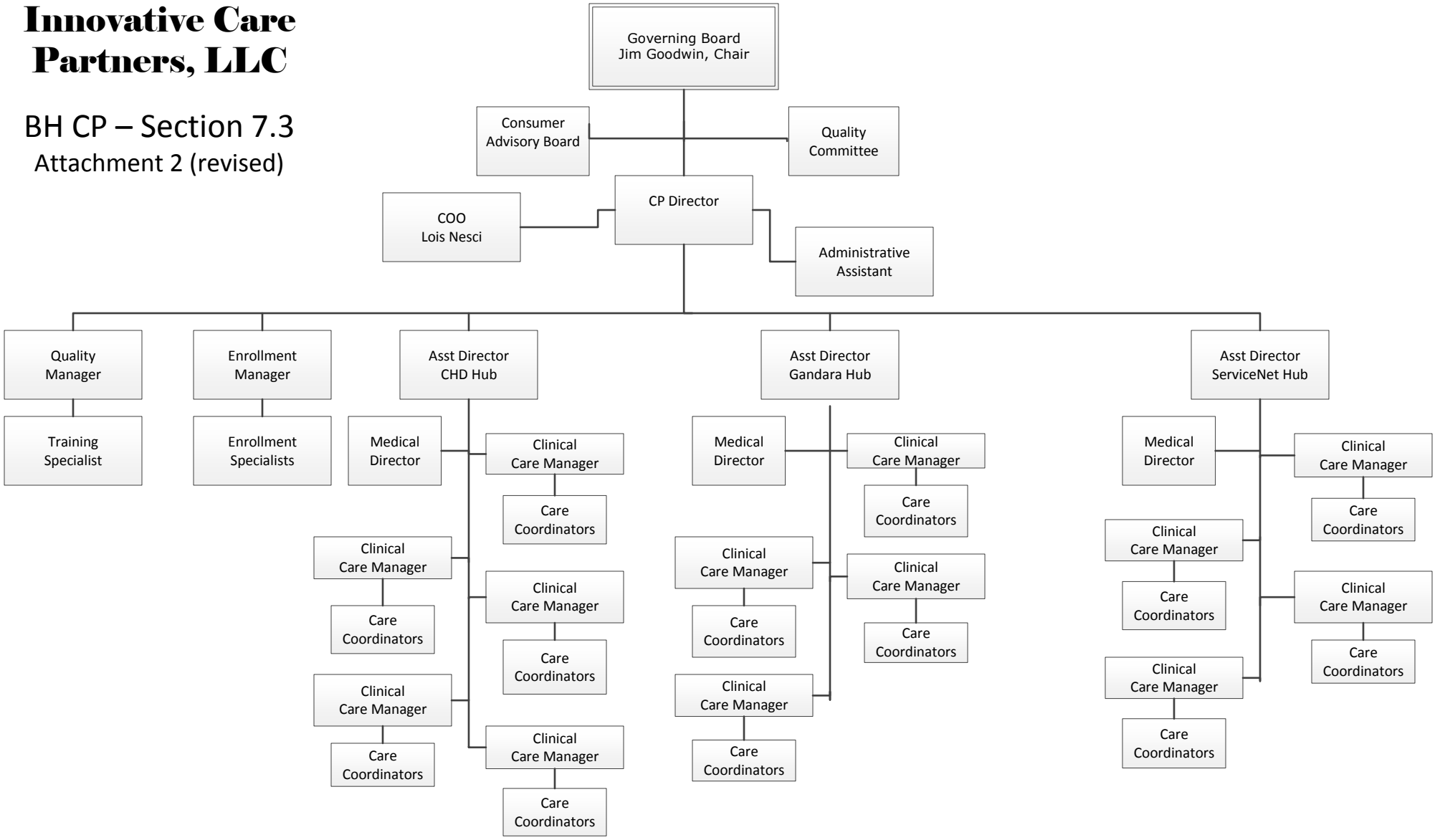
Please indicate for which Service Areas the Bidder is bidding. Please estminate the number of members the Bidder will have the capacity to support in each Service Area. ***Innovative Care Partners Behavioral Health CP***

Region	Service Area	Bidder Selected Service Areas	Estimated Number of members the Bidder will have the capacity to support within each Service Area
Greater Boston Region	BOSTON - PRIMARY		
	REVERE		
	SOMERVILLE		
	QUINCY		
Northern Region	BEVERLY		
	GLOUCESTER		
	HAVERHILL		
	LAWRENCE		
	LOWELL		
	LYNN		
	MALDEN		
	SALEM		
	WOBURN		
Southern Region	ATTLEBORO		
	BARNSTABLE		
	BROCKTON		
	FALL RIVER		
	FALMOUTH		
	NANTUCKET		
	NEW BEDFORD		
	OAK BLUFFS		
	ORLEANS		
	PLYMOUTH		
	TAUNTON		
	WAREHAM		
Central Region	ATHOL		
	FRAMINGHAM		
	GARDNER-FITCHBURG		
	SOUTHBRIDGE		
	WALTHAM		
	WORCESTER		
Western Region	ADAMS	X	135
	GREENFIELD	X	300
	HOLYOKE	X	635
	NORTHAMPTON	X	250
	PITTSFIELD	X	350
	SPRINGFIELD	X	1,975
	WESTFIELD	X	355

Innovative Care Partners, LLC

BH CP – Section 7.3

Attachment 2 (revised)



E. Personnel and staffing:

1. An **organizational chart** for the BH CP initiative is included as Attachment 2 (Revised).

2. Sample staffing model: As described in Section 7.2.B above, the CP program will operate three Service Hubs with each Consortium Entity operating one of the three Service Hub to serve Engaged Enrollees in each proposed service area, as delineated in Attachment D. The three Hubs will operate under a single set of program policies and procedures (BH CP Operating Manual).

(Figure 2)

BH CP Staffing ~~Model~~Model (revised)

Service Hubs	Service Areas and # of Enrollees	HUB Supervision	Clinical Care Manager (CCMs)	Care Coordinator (CCs)
Three Hubs:	~~6,000~~4,000 Total Enrollees:	3 FTE Asst Directors	~~21~~ 13 FTE CCMs	~~126~~ 80 FTE CCs
~~CHD Hub w/ 7 Teams~~	~~Springfield 1,350 Westfield 355 Holyoke 295~~	~~Assistant Director Supervises 7 CCMs~~	~~Seven (7) CCMs, each supervises six (6) CCs~~	~~42 CCs~~
~~ServiceNet Hub w/7 Teams~~	~~Adams 270 Greenfield 325 Northampton 300 Pittsfield 700 Holyoke 405~~	~~Assistant Director Supervises 7 CCMs~~	~~Seven (7) CCMs, each supervises six (6) CCs~~	~~42 CCs~~
~~Gandara Hub w/7 Teams~~	~~Holyoke 305 Springfield 1,695~~	~~Assistant Director Supervises 7 CCMs~~	~~Seven (7) CCMs, each supervises six (6) CCs~~	~~42 CCs~~

3. Recruitment Plan: Innovative Care Partners (ICP) will implement a robust and dynamic recruitment plan to ensure that all key roles are filled in anticipation of ~~an April 1~~June 1, 2018 start date. The CHD Human Resources Department, which includes dedicated recruitment staffing, will lead recruitment activities with support from HR departments at ServiceNet and Gandara Center, including sourcing, recruitment, and initial screening of candidates for service locations at each of the three Service Hubs. Final interviews and job offers will be made by the hiring Consortium Entity.

The Program Director will be hired by ~~November~~ December 1, 2017 so that they are in place to direct and oversee all aspects of program planning and development during the Preparation Period. Assistant Directors, one for each Service Hub, will come on board in January or February 2018. These positions will then be important leaders in the screening and hiring of all other staff scheduled to be on board and in place by ~~April~~ June 1, 2018.

ICP's extensive recruitment process begins with confirming roles, identifying core competencies and developing attractive, thoughtful job postings. ICP uses a number of online resources for advertising, including both broad-based and niche job boards. Social media is also a successful recruiting forum, so LinkedIn, Facebook, Twitter, etc. will be heavily utilized to reach a broad audience. ICP, through its Consortium Entities, has also had

success reaching out to professional and civic associations to reach those candidates with a specific educational or professional background as well as those in targeted cultural or linguistic communities. For example, ICP will post open positions with the National Association of Social Work, Spanish Nurses Association, Health Care Administrators, Vietnamese American Civic Association, Russian Community Association, National Association of Puerto Rican and Hispanic Social Workers, New North Citizens Council, Recovery Learning Center, and the Transformation Center.

ICP will host a number of job fairs throughout the seven target service areas to highlight the positions they seek to fill. ICP has extensive experience holding on-site job fairs, as well as hosting recruitment activities at local colleges and universities. ICP also has experience using large community venues for recruitment. ICP would have hiring managers available for on-site interviews with the ability to make immediate hiring decisions as needed. The professional Recruitment staff will also be available and includes a bilingual/bicultural (Spanish/English) team member.

Other recruitment strategies also include providing employee referral bonuses to staff and a direct mail campaign to licensed, professional candidates (LICSW, RN) announcing the new service and the exciting opportunities available.

4. Cultural and Linguistic Staff Diversity: Innovative Care Partners (ICP) will actively recruit staff from a variety of cultural and linguistic communities, with a special focus on bi-lingual English- and Spanish-speaking candidates. Gandara Center employs a full-time bilingual/bicultural Recruiter who will lead candidate sourcing and outreach activities, such as organizing and attending job fairs, screening, and conducting initial interviews. Furthermore, ICP staff will travel to Puerto Rico and Spain in order to reach an appropriate pool of candidates. Recruitment at universities on Puerto Rico has been a successful recruiting tool and ICP will host job fairs and other recruiting events there as well. ICP also has had success working with professional and civic associations to reach those candidates in targeted cultural or linguistic communities. Examples of organizations which have access to diverse communities include the Spanish Nurses Association, Russian Community Association, Vietnamese American Civic Association, National Association of Puerto Rican and Hispanic Social Workers, and New North Citizens Council. ICP will also recruit and hire qualified candidates with lived experience, including persons in recovery from mental illness and substance use disorders.

5. Staff Orientation and Training: Innovative Care Partners (ICP) recognizes that planning and implementing a comprehensive staff orientation and training plan is critical to the success of the BH CP program. The components of the proposed plan include: (1) orientation to CP goals, policies, procedures and individual staff position expectations and to relevant Host Hub agency policies and procedures as well as safety, privacy, and other compliance training; (2) specialized care coordination and care management training; (3) orientation to individual CP roles; and (4) management training for CP leaders. A Training Specialist will be hired to plan and oversee the CP Training and Orientation Plan. This position will report to the CP Quality Manager, but will also work closely with the CHD Vice President of Human Resources, Carol Fitzgerald, and the CP Program Director.

All new CP personnel will undergo a standardized four week pre-service provision orientation and training program that will consist of group sessions, individual on-line learning through the Relias Health Solutions Training platform, and job shadowing.

a. Orientation and Universal Training (conducted during the pre-service, orientation period, at CP Central Office and at individual Host Hub):

i. Orientation to the BH CP program: mission, values, policies and procedures, role descriptions, program organization;

ii.Training in eHana Care Coordination/Care Management Information System;

iii.Orientation to Consortium Entity Host Hub: Host agency mission, values, policies and procedures, organization, employment rules and benefit programs;

iv.Relias web-based curriculum: HIPAA, 42 CFR, and other confidentiality/privacy requirements; universal precautions and safety for human service workers; cultural diversity and human rights; and sexual harassment;

v.Human rights training, mandated by the Department of Mental Health; and

vi.First Aid and CPR Certification.

b. Specialized Behavioral Health and Community Partner (CP) Training (Initiated in the pre-service, orientation period and continuing during first year of employment):

i. Motivational Interviewing (MI) – An eight-hour training for Clinical Care Managers, Care Coordinators, Enrollment Manager, and Enrollment Specialists;

ii. Integrated Care Management Certificate Program – A 20-module, on-line learning program, conducted by UMASS Medical Center, for Clinical Care Managers and Care Coordinators. The program develops general skills for engaging Enrollees, promoting their activation to improve their own health, and general medical and behavioral health skills to be able to connect Enrollees to appropriate services, to address questions, to teach healthy living and support patient-centered Treatment Plans;

iii. Non-Violent Crisis Intervention Training:, Eight hour program, conducted by the Crisis Prevention Institute (CPI), for Clinical Care Managers and Care Coordinators to teach de-escalation techniques;

iv. Screening, Brief Intervention, Referral, and Treatment (SBIRT): Offered by the National Council for Behavioral Health, this 1 ½ hour online training in the use of SBIRT tools will assist Clinical Care Managers and Care Coordinators to assist Enrollees with possible alcohol and other substance use issues;

v. Recovery Support Navigation: Two Care Coordinators on each Care Coordination Team will attend five-day Recovery Coach Academy, sponsored by AdCare Educational Institute. The Academy teaches the principles, philosophy, and functions of Recovery Coaches; and

vi. EOHHS-Mandated or Recommended Training: ICP will cooperate with, and support the provision of, CP training programs that EOHHS may develop, sponsor, or otherwise require during the period of the Contract.

c. CP Role Orientation and Job Shadowing (conducted during the pre-service period): Each new CP staff person will spend at least one week working alongside seasoned workers to learn the details of their role. The first "wave" of staff that are hired in the Preparation Period and early part of Budget Year 1 will participate in simulated training, including Enrollee role playing.

d. Management Training: (a) A three-hour pre-service orientation to administrative services, including Fiscal, Human Resources, IT, Organizational Excellence, Development and Marketing; and (b) participation in CHD-sponsored management training programs.

6. Staff Retention Strategies: Staff retention and engagement efforts start from day one at Innovative Care Partners (ICP). ICP's orientation and onboarding efforts connect and ground new staff in the important mission of the organization and make the most of their enthusiasm and energy. Amidst all of the paperwork and policies is the strong message about mission and values that drives the work that we do in the community.

ICP offers highly competitive compensation and benefits, both in traditional and non-traditional ways. Our salaries are at or above market rates and we continually review both internal and external equity to ensure that we can attract and retain the highest skilled and credentialed staff. ICP provides sign-on and referral bonus for difficult to fill positions and offers bonuses and incentives for our clinical staff, along with reimbursement for their professional licensure. ICP has been able to provide regular bonuses, gift cards, and other financial recognition of the good work of its staff.

Insurance benefits are an important part of the benefits package and Innovative Care Partners is committed to contributing toward the majority of the health and dental insurance premiums on behalf of staff. Life insurance as well as both short and long-term disability coverage are offered to staff at full company expense and ICP provides important retirement plan benefits as well. Caring about staff's health goes well beyond insurance coverage – Innovative Care Partners has vibrant wellness activities, incentives, and initiatives in order to support staff in a myriad of ways. From non-smoking support and incentives to health-related trainings to Employee Assistance Programs, ICP supports our staff in their total health and wellness so that they can, in turn, focus on the support of those served.

ICP also recognizes that in this difficult work, it's important for staff to have a break and to have fun. As such, ICP provides generous paid time off benefits so that staff can rejuvenate and recharge and understands the importance of work/life balance. Whenever possible, ICP provides flexibility and appreciation for personal time. While staff are at work, ICP ensures that they are recognized for their good work and ICP highlights its appreciation with a variety of recognition awards and events throughout the year, including employee of the month, Star Awards, work anniversary acknowledgments and staff social events.

Another important retention strategy is ensuring that staff are well trained, well supervised, and well prepared for the next stage in their careers. To that end, ICP supports a strong learning culture with an emphasis on professional development and training. With both extensive in-person and online training opportunities, ICP staff are able to expand their clinical, administrative and management knowledge. On the job training, in-house expertise, clinical supervision and an electronic training module provide staff an array of content areas as well as forums to learn about the latest treatment models, stay abreast of compliance and safety standards, and develop important supervisory and management skills. The size and scope of the ICP member agencies also provides unique opportunities for mobility – both clinical and managerial advancement are common.

Communication and participation are important for staff to feel a commitment to an organization. Innovative Care Partners, through its Consortium Entities, has strong human resources departments to provide additional support and assistance to staff on a number of issues as well as formal open door and grievance policies to ensure that people are heard and listened to throughout their employment. ICP's Consortium Entities actively seek involvement from staff in agency-wide committees that provide guidance and direction to management. There are also a number of communication tools – email, intranet, staff meetings, open forums, etc. – that enable staff to provide input to management and for management to inform staff about issues of importance to the work that we do.

Finally, ICP's Consortium Entities are strong, stable agencies with reputations for quality services. Staff want to be part of creative, mission-driven organizations. And the organizations seek staff that are active participants and truly engaged in the important work and ongoing success of those we serve. ICP is committed to providing staff with a unique employment opportunity based on mutual respect and collaboration. The Consortium Entities have created a culture where joint problem-solving, entrepreneurial service delivery, and positive relationships thrive. All of that takes regular care and attention. Therefore, Innovative Care Partners considers retention strategies in a very broad manner – there are many things that impact someone's experience at work and keep them enthusiastic and excited about the work they do and where they do it. ICP will strive to develop strategies that support a highly engaged staff, foster creativity and enthusiasm, and recognize the individual strengths and collective power of staff to enhance people's lives.

F. Implementation Plan and Timeline (Revised 11/28/17)

Preparation Period:

Nov 2017	• ICP leaders initiate outreach to ACOs and MCOs; hold initial meeting with each ACO in Western Region service areas; • Begin Program Director recruitment.
Dec 2017-Jan 2018	• IT Vendor contract executed and project plan developed; • Bidder/Vendor IT Work Team meets regularly on software customization • Program Director Hired; Begins policy and procedures (P&P) development • Continue ACO/MCO engagement and outreach activities, including discussions toward Agreements execution; Solicits ACO suggestions on Enrollee outreach/engagement; • Program Director develops outreach/marketing materials and strategies w/CHD Marketing department technical assistance and support.
Feb 2018	• Governing Board begins review and approval of initial set of P&Ps; • Program Director establishes monthly joint operating meeting structure with each ACO; • Quality Manager hired; begins working with Program Director to establish Quality Committee; begins work with Consortium Entity QM leaders to design CP CQI Plan; • Governing Board meets, reviews and approves new policies and project plans; • Enrollment Manager hired; begins designing outreach/engagement plan w/ Program Director and CHD Marketing Dept • Program Director and Enrollment Manager bring draft outreach/engagement plan to monthly ACO joint operating meetings for input; • IT Work Team presents test-mode demonstration of customized CC/CM software to Governing Board, Program Director and Consortium Entity personnel; • Program Director initiates active outreach to community resource/collaboration agencies w/support from CHD Marketing Department; • Consumer Advisory Board membership recruitment begins.
March 2018	• An Assistant Director is hired for each Service Hub; • MCO/ACO Agreements are executed; • Training Specialist is hired; • Quality Manager presents draft CQI plan for Committee feedback and approval; • Program Director presents Policy Manual for Governing Board approval (that addresses all requirements of EOHHS Contract); • Program Director and Enrollment Manager finalize outreach/engagement plan and communicates it at each ACO joint operating meetings; • IT Work Team beta tests customized CC/CM software; develops specs for initial report set w/Quality Manager, Program Director and Assistant Directors; • Program Director, Assistant Directors, and Enrollment Director continue outreach to community resource/collaboration agencies w/support from CHD Marketing Department; • Consumer Advisory Board holds kick-off meeting; • Quality Committee holds kick-off meeting; • Business Associate Agreements (BAA) are executed with each Consortium Entity, IT Vendor, and other required third parties.
April 2018	• Two Enrollment Specialists are hired and trained; • Personnel is hired and trained to staff one Care Coordination Team at each Hub:

	• Three Clinical Care Managers (CCM)are hired for each Hub (one for each hub); 18 Care Coordinators (CCs) are hired (6 for each Hub); • IT Work Team installs CC/CM software and trains teams at each Hub; • Enrollment Department w/IT support conducts test with EOHHS and each ACO for transmittal of Assigned Enrollee data; • Consumer Advisory Board holds meets and reviews final implementation plan; • Quality Committee meets and recommends final CQI Plan for Budget Period 1 • Governing Board approves Year 1 CQI Plan.

Budget Year 1:

June 2018	• Enrollment Dept receives initial transmittal of Assigned Enrollees from MassHealth, conducts outreach to members consistent with outreach/engagement plan, and makes assignments to each Hub following approved assignment criteria; • Additional CCMs and CCs are hired and trained each month based on number of new Assigned Enrollees; • IT Team troubleshoots and resolves any system and end user problems; • Continued outreach to ACOs to facilitate and generate Enrollee Assignments; monthly joint operating conference calls with each ACO and MCO to address issues and facilitate coordination; • Continued outreach to community resources; • Quality Manager analyzes Month 1 enrollment and engagement data and distributes first dashboard reports to each Hub; Assistant Directors; • Quality Committee meets monthly to review reports; • Consumer Advisory Board meets to review Program Director report on implementation progress and provides suggestions to address outreach, engagement, and other challenges; • Progress report submitted to EOHHS as required.
July – Sept 2018	• Additional Enrollment Specialist hired and trained; • Additional CCMs and CCs are hired and trained each month based on number of new Assigned Enrollees; • Joint operating conference calls with each ACO and MCO to address issues and facilitate coordination continue on quarterly basis; • Quality Manager analyzes Quarter 1 program performance and quality data and distributes first dashboard reports to each Hub; Assistant Directors implement action plans to address below target measures; • Year 1 CQI initiative to increase Enrollee engagement rate is conducted; results are reported to Quality Committee and Governing Board; • Consumer Advisory Board meets to review Program Director report on implementation progress and provides suggestions to address outreach, engagement, and other challenges; • Progress report submitted to EOHHS as required.
Oct-Dec 2018	• Enrollee mobile app launched on pilot basis; • Additional CCMs and CCs are hired and trained each month based on number of new Assigned Enrollees; • Joint operating conference calls with each ACO and MCO to address issues and facilitate coordination continue on quarterly basis; • Quality Manager analyzes Quarter 2 program performance and quality data and distributes first dashboard reports to each Hub; Assistant Directors implement action plans to address below target measures;

	• Continue tracking data related to CQI initiative and implement action plan as needed; Report results to Quality Committee and Governing Board; • Consumer Advisory Board meets to review Program Director report on implementation progress and provides suggestions to address outreach, engagement, and other challenges; • Progress report submitted to EOHHS as required.

Year 2:

Jan-Mar 2019	• Mobile app pilot results reviewed, IT dept makes changes as needed, and app is rolled out to all interested Enrollees; • Program Director produces Year 1 report for Board and EOHHS, incorporating quality and performance data from Quality Manager; • Quality Committee and Consumer Advisory Board review Year 1 results and provide suggestions to address challenges; • First Year 2 CQI initiative is planned, with input from Quality Committee and Consumer Advisory Board; • Quarterly joint operating meetings with ACOs and MCOs continue; • Consumer and ACO/MCO surveys are designed, with input from Quality Committee and Consumer Advisory Board, approved by EOHHS, and distributed; • Planning for first annual Community Partners conference begins; • Quality Committee and Consumer Advisory Committee meet; • Progress report submitted to EOHHS as required.
April-June 2019	• Consumer and ACO/MCO survey results are analyzed and reported to Quality Committee, Consumer Board ,Governing Board, and EOHHS; action plans are developed to address areas for improvement; • First annual CP conference held; • IT enhancements related to interoperability, data analytics, and predictive analysis are tested and installed on CC/CM platform; • Quarterly joint operating meetings with ACOs and MCOs continue; • First Year 2 CQI initiative is implemented; • Quarterly joint operating meetings with ACOs and MCOs continue; • Quality Committee and Consumer Advisory Committee meet; • Progress report submitted to EOHHS as required.
July-Sept 2019	• Second Year 2 CQI initiative is planned; • Quarterly joint operating meetings with ACOs and MCOs continue; • Quality Committee and Consumer Advisory Board meet; • Joint operating meetings with ACOs and MCOs are held; • Progress report submitted to EOHHS as required.
Oct-Dec 2019	• Second Year 2 CQI initiative is implemented; • Quarterly joint operating meetings with ACOs and MCOs continue; • Quality Committee and Consumer Advisory Board meet; • Joint operating meetings with ACOs and MCOs are held; • Progress report submitted to EOHHS as required.

Year 3:

Jan-Mar 2020	• Program Director produces Year 2 report for Board and EOHHS, incorporating quality and performance data from Quality Manager; • Quality Committee and Consumer Advisory Board review Year 2 results and provide suggestions to address challenges; • First Year 3 CQI initiative is planned, with input from Quality Committee and Consumer Advisory Board; • Quarterly joint operating meetings with ACOs and MCOs continue; • Consumer and ACO/MCO surveys are distributed; • Planning for second annual Community Partners conference begins; • Quality Committee and Consumer Advisory Committee meet; • Progress report submitted to EOHHS as required.
April-June 2020	• Consumer and ACO/MCO survey results are analyzed and reported to Quality Committee, Consumer Board ,Governing Board, and EOHHS; action plans are developed to address areas for improvement; • Second annual CP conference held; • Quarterly joint operating meetings with ACOs and MCOs continue; • Second Year 3 CQI initiative is implemented; • Quarterly joint operating meetings with ACOs and MCOs continue; • Quality Committee and Consumer Advisory Committee meet; • Progress report submitted to EOHHS as required.
July-Sept 2020	• Second Year 3 CQI initiative is planned; • Quarterly joint operating meetings with ACOs and MCOs continue; • Quality Committee and Consumer Advisory Board meet; • Joint operating meetings with ACOs and MCOs are held; • Progress report submitted to EOHHS as required.
Oct-Dec 2020	• Second Year 3 CQI initiative is implemented; • Quarterly joint operating meetings with ACOs and MCOs continue; • Quality Committee and Consumer Advisory Board meet; • Joint operating meetings with ACOs and MCOs are held; • Progress report submitted to EOHHS as required.

Year 4:

Jan-Mar 2021	• Program Director produces Year 3 report for Board and EOHHS, incorporating quality and performance data from Quality Manager; • Quality Committee and Consumer Advisory Board review Year 3 results and provide • suggestions to address challenges; • First Year 4 CQI initiative is planned, with input from Quality Committee and Consumer Advisory Board; • Quarterly joint operating meetings with ACOs and MCOs continue; • Consumer and ACO/MCO surveys are distributed; • Planning for third annual Community Partners conference begins; • Quality Committee and Consumer Advisory Committee meet; • Progress report submitted to EOHHS as required.
April-June 2021	• Consumer and ACO/MCO survey results are analyzed and reported to Quality Committee, Consumer Board ,Governing Board, and EOHHS; action plans are developed to address areas for improvement; • Third annual CP conference held;

	• Quarterly joint operating meetings with ACOs and MCOs continue; • Second Year 4 CQI initiative is implemented; • Quarterly joint operating meetings with ACOs and MCOs continue; • Quality Committee and Consumer Advisory Committee meet; • Progress report submitted to EOHHS as required.
July-Sept 2021	• Second Year 4 CQI initiative is planned; • Quarterly joint operating meetings with ACOs and MCOs continue; • Quality Committee and Consumer Advisory Board meet; • Joint operating meetings with ACOs and MCOs are held; • Progress report submitted to EOHHS as required.
Oct-Dec 2021	• Second Year 4 CQI initiative is implemented; • Quarterly joint operating meetings with ACOs and MCOs continue; • Quality Committee and Consumer Advisory Board meet; • Joint operating meetings with ACOs and MCOs are held; • Progress report submitted to EOHHS as required.

Year 5:

Jan-Mar 2022	• Program Director produces Year 4 report for Board and EOHHS, incorporating quality and performance data from Quality Manager; • Quality Committee and Consumer Advisory Board review Year 4 results and provide suggestions to address challenges; • First Year 5 CQI initiative is planned, with input from Quality Committee and Consumer Advisory Board; • Quarterly joint operating meetings with ACOs and MCOs continue; • Consumer and ACO/MCO surveys are distributed; • Planning for annual Community Partners conference begins; • Quality Committee and Consumer Advisory Committee meet; • Progress report submitted to EOHHS as required.
April-June 2022	• Consumer and ACO/MCO survey results are analyzed and reported to Quality Committee, Consumer Board ,Governing Board, and EOHHS; action plans are developed to address areas for improvement; • Fourth annual CP conference held; • Quarterly joint operating meetings with ACOs and MCOs continue; • Second Year 5 CQI initiative is implemented; • Quarterly joint operating meetings with ACOs and MCOs continue; • Quality Committee and Consumer Advisory Committee meet; • Progress report submitted to EOHHS as required.
July-Sept 2022	• Second Year 5 CQI initiative is planned; • Quarterly joint operating meetings with ACOs and MCOs continue; • Quality Committee and Consumer Advisory Board meet; • Joint operating meetings with ACOs and MCOs are held; • Progress report submitted to EOHHS as required.
Oct-Dec 2022	• Second Year 5 CQI initiative is implemented; • Quarterly joint operating meetings with ACOs and MCOs continue; • Quality Committee and Consumer Advisory Board meet; • Joint operating meetings with ACOs and MCOs are held; • Progress report submitted to EOHHS as required.

Community Partner Program Budget Report

NORTHEAST BEHAVIORAL HEALTH CORPORATION

Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Estimated Enrollees- Start of Period (All Enrollees)		1,000	1,600	1,600	1,600	1,600	
Estimated Enrollees - End of Period (All Enrollees)		1,600	1,600	1,600	1,600	1,600	
Estimated Enrollees - Monthly Average (excl CBFS enrollees)		1,343	1,600	1,600	1,600	1,600	
Estimated Enrollees - Monthly Average (CBFS enrollees only)							
Estimated Program Revenue (excl CBFS enrollees)		$ 1,692,180	$ 3,456,000	$ 3,456,000	$ 3,456,000	$ 3,456,000	$ 15,516,180
Estimated Program Revenue (CBFS enrollees only)		$ -	$ -	$ -	$ -	$ -	$ -
Total Estimated Program Revenue		**$ 1,692,180**	**$ 3,456,000**	**$ 3,456,000**	**$ 3,456,000**	**$ 3,456,000**	**$ 15,516,180**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -	$ -	$ -	$ -
Revenue for Operations		**$ 1,692,180**	**$ 3,456,000**	**$ 3,456,000**	**$ 3,456,000**	**$ 3,456,000**	**$ 15,516,180**

	Program Expenses		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
1	**Salary**		$ 194,931	$ 1,419,785	$ 2,820,015	$ 2,876,415	$ 2,933,943	$ 2,992,622	$ 13,237,711
2	**Fringe**		$ 44,834	$ 326,550	$ 676,804	$ 719,104	$ 733,486	$ 748,156	$ 3,248,934
	Total Personnel Costs		$ 239,765	$ 1,746,335	$ 3,496,819	$ 3,595,519	$ 3,667,429	$ 3,740,778	$ 16,486,645
3	**Training & Professional Development**		$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	**Travel**		$ 778	$ 67,318	$ 135,606	$ 135,606	$ 135,606	$ 135,606	$ 610,520
5	**Equipment**		$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	**Supplies**		$ 3,960	$ 16,072	$ 27,552	$ 27,552	$ 27,552	$ 27,552	$ 130,240
7	**Contract Services** (consulting, professional)		$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	**Software licensing**		$ 17,440	$ 24,416	$ 43,530	$ 45,271	$ 47,082	$ 48,966	$ 226,705
9	**Telecommunications**		$ 4,200	$ 33,400	$ 69,600	$ 69,600	$ 69,600	$ 69,600	$ 316,000
10	**Occupancy** (rent, utilities, maintenance)		$ 3,563	$ 63,729	$ 114,713	$ 120,448	$ 126,471	$ 132,794	$ 561,718
11	**Other**		$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Total Direct Costs		$ 269,706	$ 1,951,270	$ 3,887,820	$ 3,993,996	$ 4,073,740	$ 4,155,296	$ 18,331,828
12	**Indirect Cost/Administrative Overhead**	**15.0%**	**$ 40,456**	**$ 292,691**	**$ 583,173**	**$ 599,099**	**$ 611,061**	**$ 623,294**	$ 2,749,774
	TOTAL EXPENSES		$ 310,162	$ 2,243,961	$ 4,470,993	$ 4,593,095	$ 4,684,801	$ 4,778,590	$ 21,081,602
	Surplus/Shortfall		*$ (310,162)*	*$ (551,781)*	*$ (1,014,993)*	*$ (1,137,095)*	*$ (1,228,801)*	*$ (1,322,590)*	*$ (5,565,422)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
VP of Population Health	$ 178,500.00	0.375	5	$ 27,891
BH CP Director	$ 90,000.00	1	4	$ 30,000
Medical Director	$ 400,000.00	0.5	5	$ -
Registered Nurse	$ 75,000.00	2	1	$ 12,500
Licensed Practical Nurse	$ 58,240.00	2	1	$ 9,707
Clincial Care Manager	$ 62,000.00	3	1	$ 15,500
Supervisors/Team Leaders	$ 42,000.00	5	1	$ 17,500
Care Coordinators	$ 38,000.00	21	1	$ 66,500
Peer Specialist/Recovery Coach	$ 38,000.00	2	1	$ 6,333
Intake Coordinator/Engagement Spclst	$ 38,000.00	1	2	$ 6,333
Administrative Support	$ 32,000.00	1	1	$ 2,667
Total Salary (Program Budget Line 1)		**38.875**		**$ 194,931**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 194,930.63	23.0%	$ 44,834
Total Fringe (Program Budget Line 2)			**$ 44,834**

Total Personnel*	**$ 239,765**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

VP of Population Health oversees all budget period preparation activities of the BH CP at .375 FTE beginning in January 2018 during the Prep Budget Period and for all future project years.

BH CP Director oversees all aspects of the program and hires, supervises and trains staff.

Registered Nurse oversees the medication reconciliation component of the program as well as reviewing medical history and comprehensive assessments.

Licensed Practical Nurse performs health screenings for members.

Clinical Care Manager oversees the Care Coordinator and Peer Specialist/Recovery Coach staff and hires, supervises and trains staff in clinical components of the program.

Supervisor/Team Leader spends 50% of the time overseeing 5 Care Coordinators, assists with training and is a resource for staff, the other 50% of the time is spent providing care coordination services to members.

Care Coordinator provides care coordination services to members.

Peer Specialist/Recovery Coach performs care management and coaching for members with substance use disorders.

Intake Coordinator/Engagement Specialist reaches out to potential members, explains the program and schedules meetings with potential members for the Care Coodinator staff.

Administrative Support schedules meetings, assists with internal and external reporting, supports program staff and maintains program records.

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost

	A	B	C	D	E	F
48						
49						
50						
51	**Total Training and Professional Development**			**$** -		
52	**(Program Budget Line 3)**					
53						
54	***Provide a description of each Training and Professional Development line item included in the table above:***					

Row 4 - Travel

	Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
86	VP of Population Health	100	5	0.485	$ 242.50
87	BH CP Director	50	3	0.485	$ 72.75
88	Registered Nurses	50	1	0.485	$ 24.25
89	Clinical Care Managers	50	3	0.485	$ 72.75
90	Supervisors/Team Leaders	50	5	0.485	$ 121.25
91					$ -
92				**Total Mileage**	$ 533.50

	Travel Expense Description	Cost

	A	B	C	D	E	F
95	Total Mileage	$ 533.50				
96	Parking and tolls	$ 244.50				
97	Public transportation					
98	Enrollee travel					
99	**Total Travel**					
100	**(Program Budget Line 4)**	**$ 778.00**				
101						
102	***Please describe how mileage estimates and other travel expenses listed above were determined . If including***					
103	***enrollee travel expenses above, please explain how these expenses will be used by enrollees.***					
104	Mileage amounts are estimated for off-site meetings and travel to satellite facilities within the 9 service regions under					
105	the BH CP. Number of months may exceed 6 due to multiple FTEs within each position that are expected to incur					
106	mileage travel costs during the period.					
107	Parking and tolls costs are estimated parking costs for meetings in Boston.					
108						
109						
110						
111						
112						
113						
114						
115						
116						
117						
118						
119						
120	**Row 5 - Equipment**					

121	Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost
122				
123				
124				
125				
126				
127				
128				
129	**Total Equipment (Program Budget Line 5)**			

130		
131	***Provide a brief description of the intended use for each Equipment line item listed above and how the estimated***	
132	***costs were determined:***	
133		
134		
135		
136		
137		
138		
139		
140		
141		
142		

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Office supplies-initial stock for staff	100	38	$ 3,800.00
Office supplies-resupply for staff	40	4	$ 160.00
Total Supplies (Program Budget Line 6)			**$ 3,960.00**

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Office supplies to be purchased for new employees is estimated to be $100 per FTE due to higher initial costs per month. As resupply occurs, the monthly amount should settle around $40 per FTE. This includes paper and toner costs for copiers, pens, pencils, notepaper, letter pads, folders, paper clips, staples, maintenance supplies, minor equipment, etc. Total costs did not include additional supplies required for second wave of new employees estimated to start on September 1, 2018 with the estimated additional 600 cases to be under care management on that date.

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			**$ -**

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
Netsmart CareConnect	$2.18 PMPM	1600	$ 17,440.00
Total Software Licensing (Program Budget Line 8)			**$ 17,440.00**

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Netsmart Careconnect requires a per member per month (PMPM) fee for the software license from the date of contract execution at the highest anticipated engaged member amount regardless of level of membership engagement in the earliest months of the BH CP. Accordingly, we estimate that the contract will be signed on January 1, 2018 and have budgeted $2.18 PMPM for six months for the 1,600 estimated engaged members at full operational capacity of the BH CP.

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Verizon Smartphones	$100/month	42	$ 4,200.00
Total Telecommunications (Program Budget Line 9)			**$ 4,200.00**

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Each employee will be issued a smartphone for care coordination software access as well as for access to CP members and staff while in the community providing care coordination. Average cost per month under the corporate plan is $100 per smartphone. There will be 42 months of this cost (for 38 devices) during the preparation budget period since some employees are expected to be hired up to 5 months in advance of the anticipated June 1, 2018 start-up date.

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent	2250	$1.58	$ 3,562.50
Utilities			$ -
Repair and Maintenance			$ -
			$ -
			$ -
Total Occupancy (Program Budget Line 10)			**$ 3,562.50**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

Rent costs (includes utilities) is based upon estimated square footage of 250 per employee for the Program Director, Registered Nurses, Engagement Specialist and Administrative Support positions. The square footage has been modified above to reflect the usage from hire date based upon a 12 month period of the lease for the cost per square foot.

Row 11 - Other

Other Direct Expense Description	Cost
Total Other (Program Budget Line 11)	

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	**15.00%**	**$ 40,456.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Indirect Cost/Administrative Overhead is computed at 15% of total direct costs and includes executive level staff who will be involved in the project as well as all other administrative support from Finance, Human Resources, Information Technology, Facilities and Purchasing.

Community Partner Infrastructure Budget Report

		NORTHEAST BEHAVIORAL HEALTH CORPORATION						
Infrastructure Investment Funding		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
PMPM Infrastructure Rate			$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
Engaged Enrollees			1,600	1,600	1,600	1,600	1,600	
Estimated Infrastructure Funds			$ 1,120,000	$ 1,652,160	$ 988,608	$ 871,680	$ 754,176	**$ 5,386,624**
At- Risk Withhold Rate				25%	44%	63%	81%	
Withhold				$ 413,040	$ 434,988	$ 549,158	$ 610,883	**$ 2,008,068**
TOTAL MAXIMUM FUNDS AVAILABLE		$ 450,000	$ 1,120,000	$ 1,239,120	$ 553,620	$ 322,522	$ 143,293	**$ 3,828,556**
Infrastructure Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology								
1 **IT Staffing including Fringe**		$ -	$ 71,668	$ 44,088	$ 44,970	$ 45,869	$ 23,393	**$ 229,988**
2 **Development Adaptation of EHR and/or Care Management System**		$ 59,718	$ 119,436	$ -	$ -	$ -	$ -	**$ 179,154**
3 **Technology for Service Delivery**		$ 45,600	$ 24,000	$ -	$ -	$ -	$ -	**$ 69,600**
4 **Other Technology Expenses**		$ 380	$ 24,000	$ 48,000	$ 48,000	$ 48,000	$ 32,000	**$ 200,380**
Total Technology		$ 105,698	$ 239,104	$ 92,088	$ 92,970	$ 93,869	$ 55,393	**$ 679,122**
Workforce Development								
5 **Workforce Development staffing including Fringe**		$ -	$ 73,190	$ 54,200	$ 55,285	$ 91,390	$ 28,750	**$ 302,815**
6 **Recruitment Expenses**		$ 10,650	$ 24,000	$ 9,000	$ 9,000	$ 13,600	$ 2,800	**$ 69,050**
7 **Training Expenses**		$ 5,250	$ 13,750	$ 12,000	$ 30,000	$ 30,000	$ 12,000	**$ 103,000**
8 **Retention Expenses**		$ -	$ -	$ -	$ -	$ 30,000	$ -	**$ 30,000**
Total Workforce Development		$ 15,900	$ 110,940	$ 75,200	$ 94,285	$ 164,990	$ 43,550	**$ 504,865**
Business Start Up Costs								
9 **Office Equipment (PBP & BP1 only)**		$ -	$ -					**$ -**
10 **Office Furniture (PBP & BP1 only)**		$ -	$ 72,000					**$ 72,000**
11 **Ramp-up Costs (PBP BP1, BP2 and BP3 only)**		$ 310,162	$ 551,781	$ 1,014,993	$ 1,137,095			**$ 3,014,031**
Total Business Start Up Costs		$ 310,162	$ 623,781	$ 1,014,993	$ 1,137,095			**$ 3,086,031**
Operational Infrastructure								
12 **Operation Staffing including Fringe**		$ -	$ 27,060	$ 27,605	$ 28,153	$ 28,714	$ 29,290	**$ 140,822**
13 **Other Operational Expenses**		$ -	$ 45,000	$ -	$ -	$ -	$ -	**$ 45,000**
Total Operational Infrastructure		$ -	$ 72,060	$ 27,605	$ 28,153	$ 28,714	$ 29,290	**$ 185,822**
14 **Indirect Cost/Administrative Overhead Rate**	15.0%	$ 18,240	$ 74,116	$ 29,234	$ 32,311	$ 43,136	$ 19,235	**$ 216,271**
TOTAL INVESTMENTS		**$ 450,000**	**$ 1,120,000**	**$ 1,239,120**	**$ 1,384,815**	**$ 330,709**	**$ 147,468**	**$ 4,672,111**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary			$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Netsmart CareConnect professional services	$ 59,718.00

	A	B
34		
35		
36		
37		
38		
39	**Total Development and Adaptation of EHR and Care**	
40	**Management System**	$ 59,718.00
41	**(Infrastructure Budget Line 2)**	
42		
43	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***	
44	***contract and how the costs were determined:***	
45	Netsmart CareConnect has been selected as the care management software solution for which the professional	
46	software design services are required. This is a non-recurring fee for the design and implementation of the CareConnect software	
47	which will allow the Care Management staff to record and track efforts and results. The cost was determined from a quote	
48	obtained from Netsmart for the solution	
49		
50		
51		
52		
53		
54		
55		
56		
57		
58	**Row 3 - Technology for Service Delivery**	
59	**Description of Expense**	**Cost**
60	38 laptops	$ 45,600.00
61		
62		
63		
64		
65		
66	**Total Technology for Service Delivery**	$ 45,600.00

	A	B	C	D	E	F	G
67	**(Infrastructure Budget Line 3)**	**$ 45,000.00**					
68							
69	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
70	***contract and how the costs were determined:***						
71	Laptop costs for 38 FTEs is based upon a quote from our vendor GreenBee Technologies, LLC. Laptops are being purchased only						
72	for full-time employees working in the program.						
73							
74							
75							
76							
77							
78							
79							
80							
81							
82							
83							
84							
85	**Row 4 - Other Technology Expenses**						
86	**Description of Expense**	**Cost**					
87	Telehealth applications-trial versions for staff	$ 380.00					
88							
89							
90							
91							
92							
93	**Total Other Technology Expenses**	**$ 380.00**					
94	**(Infrastructure Budget Line 4)**						
95							
96	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
97	***contract and how the costs were determined:***						
98	Telehealth applications estimated at $10 each (1 application per full-time employee) is estimated so that the employee can						
99	become familiar with the application which will be used with members.						

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
	$ -			$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 6 - Recruitment Expenses

Description of Expense	Cost
Job fair costs	$ 150.00
Contract recruiter	$ 10,500.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 10,650.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Job fairs will offer opportunity for potential candidates to have face to face discussions of available positions with a recruiter, allow for questions to be answered and to assist in providing viable candidates to hiring managers.

A contract recruiter will be engaged to provide assistance with recruiting activities. The anticipated contract rate is $70 per hour for150 hours, or $10,500 for the length of the contract engagement.

Row 7 - Training Expenses

Description of Expense	Cost
In-house training for all BH CP staff including	$ 5,250.00
orientation to care coordination, etc.	
Total Training Expenses (Infrastructure Budget Line 7)	**$ 5,250.00**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

In-house training for all BH CP staff including orientation to care coordination. It is expected that this will be a week-long series of meetings which will be held in-house at the administration offices and will feature guest speakers as well as discussions among staff members regarding best practices, lessons learned, etc. from other care management/care coordination activities that management and staff have experienced. Basic medical training and all aspects of the in-house developed Care Management Onboarding orientation will be presented at the week-long training series. Estimated cost includes food for program participants and program speakers. Cost per FTE for this training is $138.15.

Row 8 - Retention Expenses

Description of Expense	Cost

	A	B	C	D	E	F	G
199							
200							
201							
202							
203							
204	**Total Retention Expenses**						
205	**(Infrastructure Budget Line 8)**						
206							
207	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms***						
208	***of the CP's contract and how the costs were determined:***						
209							
210							
211							
212							
213							
214							
215							
216							
217							
218							
219							
220							
221							
222							
223	**Community Partner <u>Infrastructure</u> Budget Report - Business Start Up Costs - Prep Budget Period**						
224							
225	**Row 9 - Office Equipment**						
226	Description of Expense	Cost					
227							
228							
229							
230							

	A	B	C	D	E	F	G
231							
232							
233	**Total Office Equipment**						
234	**(Infrastructure Budget Line 9)**						
235							
236	***Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were***						
237	***determined:***						
238							
239							
240							
241							
242							
243							
244							
245							
246							
247							
248							
249							
250							
251							
252	**Row 10 - Office Furniture**						
253	Description of Expense	Cost					
254							
255							
256							
257							
258							
259							
260	**Total Office Furniture**						
261	**(Infrastructure Budget Line 10)**						
262							
263	***Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were***						

determined:

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe (Infrastructure Budget Line 12)	**$** -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 13 - Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses (Infrastructure Budget Line 13)	

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**15.00%**	**$ 18,240.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Indirect Cost/Administrative Overhead is computed at 15% of total direct costs and includes executive level staff who will be involved in the project as well as all other administrative support from Finance, Human Resources, Information Technology, Facilities and Purchasing.

	A	B	C	D	E	F	G
358							
359							
360							
361							
362							

Community Partner Infrastructure Allocation Worksheet

	Insert Contractor Name Here						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 1,120,000	$ 1,239,120	$ 553,620	$ 322,522	$ 143,293	$ 3,828,556
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL INVESTMENTS	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Development and Adaptation of E.H.R/Care Management System	Execute contract with software vendor	11/01/17	01/01/18	contract will be executed by 1/1/2018	executed contract			contract will be executed			
Technology	Development and Adaptation of E.H.R/Care Management System	software deliveray and installation	03/01/18	03/01/18	installation of care management software	installation of care management software			care management software will be installed			
Technology	Training Expenses	Care management software "train the trainer" scheduled with BH CP Director	04/01/18	04/01/18	BH CP director trained on care management software	BH CP director trained on care management software			BH CP Director will be trained on care management software			
Technology												
Workforce Development	Retention Expenses	retain 4-6 Care Coordinators and 2-3 clinical care managers from CHART	03/01/18	03/01/18	4-6 Care Coordinators and 2-3 clinical care managers from CHART will be hired by LHBS for BH CP	4-6 Care Coordinators and 2-3 clinical care managers from CHART will be hired by LHBS for BH CP as of march 2018			4-6 Care Coordinators and 2- 3 clinical care managers from CHART will be hired by LHBS for BH CP			
Workforce Development	Workforce Development Staffing including Fringe	Hire remaining care coordinator staff, RNs, LPNs	03/01/18	05/01/18	RN, LPNs and care coordinators will be hired to support 1,000 Members as of may 2018	RN, LPNs and care coordinators will be hired to support 1,000 Members as of may 2018			RN, LPNs and care coordinators will be hired to support 1,000 Members as of may 2018			
Workforce Development	Training Expenses	Care coordinator, RN, LPN staff will participate in BH CP training including training in care management software.	05/01/18	06/01/18	Care coordinator, RN, LPN staff will complete in BH CP training including training in care management software.	Care coordinator, RN, LPN staff will complete in BH CP training including training in care management software.			Care coordinator, RN, LPN staff will complete in BH CP training including training in care management software.			
Workforce Development												
Business Start Up Costs	Development and Adaptation of E.H.R/Care Management System	expense due to software vendor at execution of contract to conduct the build of the platform for BH CP	11/01/17	01/01/18	the BH CP softward platform is built by the vendor	the BH CP softward platform is built by the vendor			the BH CP softward platform is built by the vendor			
Business Start Up Costs	Other Operational Expenses	Secure space in NE region for BH CP staff	01/01/18	05/01/18	finalize lease arrangements for properties in NE region for BH CP staff	lease arrangements will be finalized for properties in NE region for BH CP staff			Properties will be securred in the NE region for BH CP staff.			
Business Start Up Costs	Program Staffing including Fringe	Hire BH CP Director	11/01/17	12/01/17	BH CP Director will be hired by december 2017	BH CP Director will be hired by december 2017			BH CP Director will be hired			
Business Start Up Costs												
Operational Infrastructure	Ramp-up Costs	VP of Population Health support of recruiting efforts for BH CP Director as well as BH CP deliverables	10/01/17	12/01/17	VP of Population Health will hire BH CP Director as of december 2017	VP of Population Health will hire BH CP Director as of december 2017			VP of Population Health will hire BH CP Director as of december. VP will continue to provide leadership to the BH CP Director and BH CP program.			
Operational Infrastructure	Technology for Service Delivery	management of ongoing costs for care management softward	01/01/18	06/01/23	initiation of software reoccuring costs	ongoing use of care management software			ongoing use of care management software			
Operational Infrastructure												
Operational Infrastructure												

BH Community Partner - Staffing Model

NORTHEAST BEHAVIORAL HEALTH CORPORATION

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	1600	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	1.375	*Total management oversight of BH CP*
3	Medical Director	0.5	*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs	2	
5	Clinical Care Managers (RN) LPNs	4.4	*Do not include FTEs listed in line 4 (these are LPNs)*
6	Clinical Care Managers (LPHA)	4	*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders	8	*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff	0	*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	34	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)	2	*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists	1	
12	Administrative Support	1	
13			
14	Total FTE	58.275	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1:250	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	1:4.5	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff: The 8 supervisors/team leaders will directly supervise the care coordinator staff.

BH Community Partner - Staffing Model

NORTHEAST BEHAVIORAL HEALTH CORPORATION

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	1000	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	1.375	*Total management oversight of BH CP*
3	Medical Director	0.5	*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs	2	
5	Clinical Care Managers (RN) LPNs	2	*Do not include FTEs listed in line 4 (these are LPNs)*
6	Clinical Care Managers (LPHA)	3	*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders	5	*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff	0	*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	21	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)	2	*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists	1	
12	Administrative Support	1	
13			
14			
	Total FTE	38.875	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1:250	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	1:4.5	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff: The supervisors/team leaders will directly supervise the care coordinator staff.

SECTION 7.3. INITIAL DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PARTICIPATION PLAN

7.3.A. Executive Summary

Lahey Health Behavioral Services (LHBS) would like to become a Community Partner (CP) to improve the lives, health and well-being of individuals with SMI and/or SUD, and to be a part of this ground-breaking new program. We will leverage our 60 years of experience as an innovative provider organization to charter this new course in care delivery on behalf of MassHealth members.

The current healthcare system does not work well for adults with high Behavioral Health (BH) needs and lacks the very supports such as care coordination and care transitions that are so critical to outcomes of both cost and quality. High rates of mortality and morbidity, and poor health outcomes indicate a poor use of resources. Further, many of our members with high BH needs experience a range of adverse, economic, social and environmental conditions that weigh negatively upon health and functional outcomes.

As a CP, we will be able to address the full range of needs that MassHealth members face. That includes medical, behavioral health, long-term services and supports and the social determinants of health. With DSRIP funds, we will leverage our previous experience to build a solid program based on emerging and evidence-based practices, and hire a diverse care team with the expertise and the experience needed to provide supports in a person-centered, yet culturally and linguistically competent manner.

Enrollees, Service Areas, and Timeframes

LHBS proposes to serve 1,600 MassHealth members and to operate and provide services and supports to all 9 service areas in MassHealth's northeast region, including Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem and Woburn. LHBS will comply with all EOHHS requirements to operationalize the CP program and implementing such supports and activities. We will have the capacity to serve 1,000 enrollees on Day 1 and 1,600 by month 4.

Goals, Challenges, Solutions

LHBS has outlined its goals and related challenges and offers several solutions to the challenges in *Table 7.3-1* below. We will continually work to address these challenges over the 5 year contract term.

Table 7.3-1: LHBS Goals, Challenges, and Proposed Solutions

Goal	Description of Goal, and Related Challenges

Table 7.3-1: LHBS Goals, Challenges, and Proposed Solutions	
Goal	**Description of Goal, and Related Challenges**
Goal 1. **Relationships**	Challenge: The current healthcare, BH and social service system is fragmented and both members and providers do not know who to go to for answers or resources. Forming relationships across settings is not easy given resistance and competing priorities. Goal: LHBS will create strong relationships with members, ACOs, MCOs, providers, independent living centers, recovery living centers, communities, housing agencies, food banks, police stations, and others to facilitate success as a CP and to meet members' needs. We will also leverage information technology solutions to support these relationships. Proposed Solution(s): We will emphasize frequent communication with all appropriate community and provider stakeholders regarding member care, and will continually educate community organizations about our role and value. We will leverage information technology (IT) solutions as necessary to meet these goals.
Goal 2. **Workforce**	Challenge: The BH CP program success is highly dependent on recruiting and retaining the right people in a highly competitive market. Goal: LHBS will create a strong workforce of care coordinators, care managers, community health workers, and any other categories needed to implement program and meet the needs of our members. Proposed Solution(s): LHBS will leverage current connections in the community to recruit and retain highly qualified persons of our communities to serve our members. Ramp-up period includes planning for recruitment.
Goal 3. **Protocols/Tools Process.**	Challenge: LHBS needs to ensure consistency and effectiveness across the CP program and with other providers (ACOs and MCOs) to deliver high-quality, accountable care in challenging circumstances. Goal: We intend to deliver consistently excellent care to our members to demonstrate the value to EOHHS and the ACO and MCO partners. Proposed Solution(s): LHBS will leverage our existing protocols, processes and tools to support the implementation of CP services and supports and to achieve the intended outcomes. We will continually search for ways to improve our processes to align with best practices and evidence-based care guidelines.
Goal 4 **LTSS**	Challenge: Integrated care management for members who have BH and LTSS needs can be challenging. Goal: LHBS will bring best practices to serving all BH CP assigned and engaged enrollees with LTSS needs. Proposed Solution(s): We will leverage our experience and relationships with organizations in the community to implement an LTSS management program that is responsive to members' individual needs, inclusive of best practices and financially responsible.
Goal 5. **Value Proposition**	Challenge: Sustainability of the CP program beyond the 5-year contract requires demonstrating value proposition to ACOs, MCOs and other providers. Goal: LHBS will maximize performance on quality, cost and member experience metrics to demonstrate value. Proposed Solution(s): We will work with ACOs and MCOs and other providers during the 5 years to establish a framework and conduct an analysis of the data to demonstrate our value.

7.3.B. Supporting Populations and Community Engagement

LHBS knows that the best way to support our members is to engage the communities in which they live, eat, pray, work, socialize and get care. At the same time, understanding the culture, the strengths and the barriers that members face helps identify and meet the needs in a person-centered manner. LHBS has well-established connections to the community and will grow these connections to the community to serve the person-centered needs of our assigned and engaged enrollees. We will ensure that staff is informed of community resources over the course of the contract term and beyond. We will meet all requirements of the contract including those included in *Section 2.3.H* of the Model Contract to build all required community collaborations and coordination.

Connections to the Community

For 60 years, LHBS has been a community provider of a robust continuum of BH services in the northern region in the communities and service areas in which we propose to operate as a CP. As discussed in section 7.2, LHBS has a strong footing throughout the northern region, where we provide services to MassHealth members with BH needs, and where we have developed collaborative relationships with other community-based providers, social service organizations, housing/shelter providers and social service organizations. We currently provide services to members in all service areas. We are a Community Service Agency (CSA) for Cape Ann and Haverhill. We operate three Emergency Services Programs (ESPs) in four locations in Salem, Haverhill, and Lawrence, serving 37 cities and towns collectively. Our CSP, HFY and CHART care coordinators have developed processes for referral and coordination with a broad array of service providers in order to meet the unique needs of our members. In addition, we have established relationships with housing agencies, fuel assistance programs, faith-based and social-service organizations, in addition to state agencies.

As a CP, we will grow these connections to the communities in all nine service areas within the northern region to ensure that we are have the connections to address the needs of our enrollees, including those needs that are identified in the person's treatment plan and to support the enrollee's health and well-being. Building a strong system of connections is critical to our ability to meet our enrollee needs for community-based social services and flexible services.

See *Table 7.3-2* for an overview of our current connections to the community by the areas of needs.

Table 7.3-2: List of Current Connections to the Community

Area of Need	Active Relationships in all 9 services areas in the Northeast region
State Agencies	Department of Mental Health (DMH), Department of Children and Family (DCF), Department of Youth Services (DYS), Department of Developmental Services (DDS), Department of Early and Secondary Education (DESE), DPH
Local/Municipalities	All city and towns within the service areas
Housing	Shelters, housing support programs, Local public housing entities
Education	Schools, universities
Health Care	Primary care providers, local chapters, community hospitals, urgent care centers

Community-based Organizations	Recovery Learning Communities (RLCs), Independent Living Centers (ILCs), Clubhouses, local chapters of NAMI, YMCAs, faith based groups
Law Enforcement	Local police departments, court clinics

Plans to Grow Connections and to Keep Staff Informed of Community Resources

LHBS is in the process of developing protocols to grow both our relationships with community organizations and our staff knowledge about the resources available in our communities to meet member needs, and the needs we anticipate in our CP assigned and engaged members. Through our experience with members with SMI and SUD, we have learned that diverse engagement strategies are needed to achieve the goals and the vital importance of close coordination between care providers and supportive community resources in achieving treatment goals and preventing relapse. The dramatic ramp-up of our care coordination program from the current HFY portfolio will necessitate that we expand our network consciously to meet the new needs.

We will pursue several strategies to both strengthen and expand our community connectedness:

1. ***Relationships with Care Coordinators*:** Our care coordinators will be on the front-lines of efforts to identify new partners in the communities driven by the needs of individual members. Themselves members of the communities in which we work, we will leverage the personal and professional connections of our new staff to build trusting relationships with community partners.
2. **Expanded resource manual of community resources:** To make sure all new and existing staff are aware of the resources and partnerships we have in the community, we will make expand our current resource manual to include the range of community resources needed by our members.
3. **Identify gaps in our community partnerships:** As care coordinators and other staff identify gaps in the community resources available within our manual, we will document these gaps and work diligently to identify new partners to meet needs.
4. **Work closely with SMI and SUD-focused organizations:** Given their central role in advocacy and service delivery for our target populations, we will coordinate closely with Independent Learning Centers (ILCs) and Recovery Learning Centers to coordinate care for members and ensure our programs are accountable to their expectations on a macro level.

Table 7.3-3 below provides an overview of our community connections, specific to members with SUD.

Table 7.3-3: Community Connections Specific to Members with SUD

#	Description of Connection
1	On our Danvers campus, we offer the evidence-based Allies in Recovery (AiR) program to assist families to understand addiction and learn behavioral strategies to support family members with addictive disorders.

Table 7.3-3: Community Connections Specific to Members with SUD	
#	**Description of Connection**
2	We actively participate in the Danvers and Gloucester Prevention Coalitions, as well as participate in the multi-agency group in Gloucester focused on identifying and coordinating care for high risk persons in the community with acute and chronic behavioral health disorders. We have developed relationships with local police departments to expedite treatment access. Burlington and Tewksbury Police Departments work closely with our detoxification program in Tewksbury to admit individuals. Additionally, LHBS has a clinician embedded in the Danvers Police Department and fiscally and clinically supports a master's level clinician working with the Gloucester Police Assisted Addiction and Recovery Initiative (PAARI).
3	All programs provide overdose prevention education and have overdose prevention plans for the program itself, as well as individualized plans for the people we serve, including providing access to the lifesaving medication naloxone.

7.3.C. Community Partner Supports and Activities

7.3.C.1. Outreach and Active Engagement

LHBS is committed to supporting and coordinating services with and on behalf of members with high behavioral health needs and lived experience of SMI and SUD through collaboration and in partnership with clinicians, providers, ACO and MCOs. Our model is designed to integrate all services and achieve the triple aim: improve the quality of life for members, improve their health outcomes and reduce cost. LHBS has developed a plan and an associated workflow to implement all supports and activities that reflects not only our deep understanding of SMI and SUD progression and treatment processes, but also our long and successful track record program implementation. See *Section 7.3.C.7*, *Figure 7.3-1* for LHBS' workflows in support of providing CP Supports in accordance with the contract.

We are eager to address the needs of assigned and engaged enrollees in a holistic manner and assume responsibility for coordination of activities including outreach and active engagement, comprehensive assessment, care coordination and care management, care transition, medication reconciliation, health and wellness coaching, and in making their connection to community and social services. LHBS' plan includes leveraging innovative technologies, building on our already strong care management staff, and a process for coordinating with ACOs and MCOs that will help to drive our success in meeting all performance requirements and the long-term sustainability of our program.

Leveraging Experience and Evidence-Based Practices to Provide CP Supports

As covered extensively in *Section 7.2*, LHBS brings a breadth and depth of experience, 60 years in the making, in providing services to individuals with high BH needs and lived experience of SMI and/or SUD. We will leverage our experience in providing care coordination and care management to enrollees with high BH needs from the CSP, ICC, HFY and CHART programs. These four programs represent our evolution in care coordination and development of best practices. Our approaches, processes, protocols, and workflows respect our values of person-centeredness and recovery, our respect for the individual, and our deep understanding of the complexity of the diagnostic conditions of SMI and SUD that are often accompanied by other co-morbidities of health, functional needs, and social and economic needs that require additional services and supports to achieve better outcomes. We are committed to achieving the range of quality measures that are included in the model contact and will leverage our vast experience and new learning to do so.

Through all our programs, we have gained experience and expertise in addressing the needs of individuals with complex social determinants that affect health including homelessness.

See *Table 7.3-4* below for a summary description of how LHBS will provide the required CP supports and activities to improve the lives of persons with lived experience of SMI and/or SUD.

Table 7.3-4: How Will LHBS Provide CP Supports and Activities?

CP Services and Activities	Current Exp.	Our Approach, Plan, and/or Process for Meeting Contract Requirements and Leveraging the Evidence Base

Table 7.3-4: How Will LHBS Provide CP Supports and Activities?			
CP Services and Activities		**Current Exp.**	**Our Approach, Plan, and/or Process for Meeting Contract Requirements and Leveraging the Evidence Base**
1	Outreach and Engagement; Signed Participation Form	✓	• Hire an engagement specialist to help assigned enrollees connect with a care coordinator and to engage. Engagement specialists will use our already developed script to inform the process and to help engage persons with high BH needs. • Tailor our outreach and engagement to individuals based on their lived experience of SMI and/or SUD to reflect a person-centered process that accounts for social and economic circumstances, LTSS needs, disability needs, and cultural and linguistic needs of the individual. • Leverage existing LHBS infrastructure and community partnerships to maximize engagement opportunities and find members where they are.
2	Comprehensive Assessment; Person-Centered Care Treatment Plan	✓	• Use an EOHHS-approved tool. • Ensure CP engagement and participation. • Conduct the assessment involving the care team. • Meet all timelines. • Review all information for care plan development, including coordination with medical providers. • Make plans person-centered. • Ensure enrollee, and PCP approval of the plan. • Provide copies of plan to enrollee, and share PCP-approved care plans with all. • Update assessments and/or care plans regularly as circumstances change.
3	Care Coordination and Care Management	✓	• Build a relationship with the CP enrollee. • Leverage the breadth and depth of our experience. • Ensure on-going communication with the member and the entire care team. • Address the comprehensive needs of our members, including LTSS needs. • Address the social determinants of health.
4	Care Transitions	✓	• Be involved in every care transition including transitions across providers. • Be involved throughout the hospital stay. • Be involved after the hospital stay including a visit within 48 hours of discharge to coordinate care • Coordinate, and communicate with ACOs, MCOs.
5	Medication Reconciliation	✓	• Designate an RN on the care team to perform the medication reconciliation. • Use centralized enrollee record and electronic interfaces to ensure medication list is comprehensive and up to date • Create a person-centered process. • Involve and engage the CP enrollee. • Integrate medication reconciliation into workflows.
6	Health & Wellness Coaching	✓	• Develop procedures that reflect our programs and methods. • Leverage our existing network of embedded clinicians and programs to help enrollees with smoking cessation, chronic care management, and diabetes management, which will be included in the person-centered care plans.

Table 7.3-4: How Will LHBS Provide CP Supports and Activities?			
CP Services and Activities		**Current Exp.**	**Our Approach, Plan, and/or Process for Meeting Contract Requirements and Leveraging the Evidence Base**
7	Connections to Community and Social Services	✓	• Assess social needs using a screening tool. • Build an inventory of resources. • Hire people with local knowledge and experience • Make recommendations about Flexible Services • Work with ACOs to monitor and track outcomes to establish a base of evidence around the contribution that Flexible Services make to outcomes. • Assist enrollees in accessing services.

Plans for Outreach and Active Engagement

LHBS has developed a plan for contacting and helping assigned enrollees learn about what LHBS can offer (outreach) and providing supports and activities (engagement) that meets all requirements of the contract, as summarized in *Table 7.3-5*, below. In carrying out this plan, LHBS will leverage its robust portfolio of "best practices" drawn from what we have used in our care coordination programs, what we have learned from others, and what we know works.

Table 7.3-5: Outreach and Engagement			
#	**CP Supports and Activities**	**Our Commitment to CP Goals and Contract Requirements**	**Our Approach for Meeting All Requirements with Evidence-Based, Emerging and Best Practices**
1	Outreach and Engagement	LHBS intends to meet all contract requirements based upon the development, implementation, maintenance and adherence to an EOHHS-approved protocol. LHBS will: (1) conduct at least 1 outreach activity within 30 days of assignment; (2) conduct at least one face to face visit within first 3 months; and, (3) assign a Care Coordinator to assigned enrollee within 5 business days of signed participation form.	LHBS will bring its experience and evidence-based practices in conducting outreach, engaging members and conducting an effective process to obtain and document member agreement, based upon our successful track record in these for programs: CSP, ICC, HFY and CHART.

Best Practices in Outreach and Active Engagement

We have developed a strong portfolio of best practices from our experience in offering care coordination and care management in the CSP, ICC, HFY and CHART programs. These best practices include providing tailored training to our staff, putting "boots on the ground," conducting face-to-face visits, embedding staff in outpatient practices and forging partnerships with providers such as Independent Learning Centers (ILCs).

We have also looked beyond Massachusetts to support and to amplify our approach. A 2014 Center for Health Care Strategies report "Outreach to High-Need, High-Cost Individuals: Best Practices for New York Health Homes" summarizes many of the strategies that we have used in our programs including: hiring the right people for the job and from the communities in which

members live, putting "boots on the ground," tailoring outreach and engagement activities to targeted population groups, being persistent, developing customized marketing materials to give to providers, setting up timely notification processes with partners, leveraging all forms of communication and social media, and using technology.

Finally, a 2016 National Alliance on Mental Illness (NAMI) report on "Engagement: A New Standard for Mental Health Care" brings forth a critical point about engagement that LHBS will bring to this program, which is the need to create a "culture of engagement" based upon trust and recognizing that engagement is not a one-sided relationship for any person, and especially for those with lived experience of SMI and SUD. A relationship is about trust and respect, and many other important intangibles to LHBS.

The Plan to Conduct Outreach and Active Engagement

LHBS will develop, implement, maintain, and adhere to an EOHHS-approved protocol for Outreach and Active Engagement of Assigned Enrollees that meets all contract requirements and is based on best practices. This includes a three-pronged approach to engaging our members.

Engagement Specialists: For the CP program, LHBS intends to hire dedicated Engagement Specialists who will be tasked with connecting with and engaging members who are newly assigned to LHBS. The staff will outreach as soon as possible (within 30 days) by phone, making at least 3 attempts at different times of day and days of the week. If unable to connect by phone, the Engagement Specialist may attempt or arrange for an in-person attempt to connect in the community or at home. Engagement Specialists will receive specialized training in motivational interviewing and other techniques that maximize effectiveness.

We know from our experience in our other care coordination/care management work of HFY and CHART that engagement rates in a medically and behaviorally complex population are a challenge. Specifically, our engagement rate for members served by our HFY CCs is 42 percent. It is markedly lower, at 25%, for our CHART members who are high ED utilizers. We strongly believe that dedicating resources to engagement will improve our overall engagement rate.

Leverage LHBS Infrastructure: Many of the members assigned to the CP program will have additional, trusting relationships with LHBS programs in the community. LHBS will cross-train staff in these programs to identify CP members when they engage in these programs and help make connections to the Engagement Specialists or care coordinator staff. These connections will be especially important upon discharge from detox or from an ESP assessment in emergency departments. By making these connections across the system, LHBS will maximize engagement opportunities.

Leverage Community Relationships: LHBS will outreach to various community organizations in order to boost engagement of high risk individuals, including outreach to needle exchange programs, homeless shelters and ACO providers. Members often have a trusting relationship with these organizations or individuals and demonstrating integration will assist with building trust with our care managers as well.

Once contacted, LHBS will provide assigned enrollee information about the benefits, design and purpose of the CP Supports; providing the assigned enrollee information on the process for

Engaging with the program team and providing opportunities for an assigned enrollee to opt out of receiving CP Supports or to request assignment to a different CP. Engagement Specialists will gain member consent for participation in the program and ensure that a follow-up face to face visit is completed within 30 days.

7.3.C.2. Process for Comprehensive Assessment and Person-Centered Treatment Planning

LHBS has developed a process for conducting comprehensive assessments, for conducting person-centered treatment planning, and for developing/documenting/updating the plan, and ensuring plan approval by the enrollee. Like all LHBS processes, the workflow for assessments and treatment planning recognizes two important principles: that this plan belongs to the person, and as such, must be a living, breathing document that is changed and revised to reflect the changes that take place in that person's life.

LHBS intends to meet all requirements of the contract, as summarized in *Table 7.3-6*, and to leverage its best practices, as well as those from programs around the state and the country, to ensure that we achieve high rates of success evaluated under EOHHS-anticipated quality measures of engagement. (Source: Exhibit 2: Anticipated BH CP Quality Measure Slate.)

LHBS is experienced in conducting comprehensive assessments and in developing person-centered treatment plans that are inclusive of the medical and BH conditions and social determinants of health. LHBS believes that this assessment tool will play a critical role in shaping the development of a person-centered care treatment plan that addresses the medical, behavioral, LTSS and non-medical needs of the assigned enrollee, achieving positive outcomes for the enrollee, and meeting BH CP performance metrics as outlined in the model contract.

Table 7.3-6: Comprehensive Assessment and Person–Centered Treatment Planning

#	CP Supports and Activities	Our Commitment to CP Goals and Contract Requirements	Our Approach for Meeting All Requirements with Evidence-Based, Emerging and Best Practices
2	Comprehensive Assessment and Person-Centered Treatment Planning	LHBS intends to meet all contract requirements including: (1) complete assessment within 3 months of assigned enrollee's assignment; (2) annually develop person-centered treatment plan within 3 months of assignment; and, (3) reassess and update plan at least every 6 months.	LHBS will bring its experience and evidence-based practices in conducting comprehensive assessments of the enrollee's needs across several of its existing programs including, but not limited to: OP, ESP, CBHI, Here For You and CHART. Our experience and evidence-based practices are described in *Section 7.2.*

The Process to Conduct Comprehensive Assessments

1. **Use an EOHHS-Approved Tool.** LHBS will use an EOHHS-approved comprehensive assessment tool that captures all 21 assessment elements, as outlined in the model contract. See *Section 7.3.C.7.2* for our proposed Comprehensive Assessment Tool that encompasses all 21 elements. We have summarized these 21 elements into three categories in *Table 7.3-7* below and into three distinct categories: needs that are medical, needs that reflect a range of personal needs, and needs that reflect a range of social, economic and personal conditions.

2. **Engage CP Enrollee.** LHBS will ensure the participation of assigned enrollees in this assessment process. Nine years ago, LHBS began working directly with MassHealth members to ensure their successful participation in the assessment process. Evidence of success can be found in ICC, CSP, HFY, and CHART.
3. **Conduct Assessment, Involving the Right People.** LHBS Care Coordinators will conduct the Comprehensive Assessment with members of the Care Team; and within all required timeframes. A Registered Nurse (RN) will review all medical history, medical need and medications, connecting with the PCP, other medical or BH providers, or other participants in the member's support structure as needed for completeness. A Clinical Care Manager on the CP Team will complete final review and approval of the entire comprehensive assessment. Additionally, the Team Leader will be responsible for ensuring that the results of the Comprehensive Assessment are communicated to the assigned enrollee's Care Team, ACO and/or MCO, and other providers who serve the assigned enrollee including state agencies or other case managers as appropriate.
4. **Leverage Care Management Tools to Meet Timelines.** We will leverage the care management tools to ensure that all requirements for timely completion of the assessment. (We are currently considering the selection of our care management software tool for this program. We are comparing the benefits of three well-known choices on the basis of cost and quality.)

Table 7.3-7: LHBS Summary of the Assessment Tool

Category	Medical Care	Personal/Required Supports	Social and Economic/Other
Elements	Immediate care needs; Current services; Medical history; Medications.	Ability to communicate concerns, symptoms, or care goals; Functional status; Self-identified strengths, weaknesses, interests, care goals, and personal goals; Current and past mental health and substance use; and Accessibility requirements.	Housing and home environment; Employment status, professional interests, and professional goals; Current use of and goals for leisure time; Legal status; Education; Income and financial support; Available supports; Risk factors for abuse/neglect; Food security, nutrition, wellness and exercise; Advance directives status and preferences and guardianship status; Current and relevant acute care plans for medical and BH conditions; and, Other domains.

The Process to Develop Person-Centered Treatment Plan

LHBS has extensive experience in developing person-centered treatment plans. See *Section 7.3.C.7.3* for a sample plan that reflects the information that is captured in our electronic record systems today for PCPs to access. This plan is always available to the member.

LHBS will develop the person-centered treatment plan within 3 calendar months of the enrollee's assignment to LHBS. We will implement a process that encompasses the following key steps and meet all required timeframes. We will also ensure that plans are always available to CP enrollees and other members of the care team. We consider the plan a living, breathing document that will be updated as needed, and at least every 6 months.

Our approach to care planning and treatment planning is based on bringing together a balance of natural and formal supports that may include family/guardian, supports, providers, schools, state agencies, clergy and others who play a key role in the youth's life. We adhere to the

Wraparound Principles which include: Family voice and choice, Team-based, Natural Supports, Collaboration, Community-based, Culturally-competent, Individualized, Strengths-based, Unconditional, and Outcome-based.

Specific steps in developing the treatment plan include:

1. **Engage CP Enrollee.** Ensure that enrollees have an opportunity to develop his/her person-centered treatment plan that emphasizes the strengths and priorities of the enrollee.
2. **Review All Information.** Collect all information relevant to the development of all person-centered treatment plans include all results, assessments for social services, and include all other required information such as reassessment dates. To the extent that the enrollee may have complex medical conditions co-morbid with SMI or SUD, consult with the PCP on treatment plans and goals.
3. **Make the Plans Person Centered.** Create person-centered treatment plans are unique to each enrollee, in writing, reflect preferences and needs of the individual and meets all other requirements to support a disability-competent and culturally-competent process, and are approved by the assigned enrollee's PCP or PCP designee and the assigned enrollee.
4. **Ensure Enrollee and PCP Approval.** Ensure that all updated person-centered treatment plans are approved by engaged enrollees and the engaged enrolled PCPs or PCP designee.
5. **Provide Copies of PCP-Approved Plans to All**. Provide all engaged enrollees with a copy of the PCP-approved person-centered treatment plan, or updated one. Share person-centered treatment plans with all parties.
6. **Re-assess and update** all person-centered treatment plans, as appropriate including after care transitions and other changes in status.

Highlight on Care Planning and Treatment Plans for Youths: *LHBS has nine years of experience in care planning for MassHealth youth and their families. The Care Team develops a clear mission statement that articulates the overarching goal of the service provision, examine the youth and family's needs, identify several different ways to meet those needs that match up with our strengths. During care plan meetings, the team will: review accomplishments (what we have done and what's been going well); assess whether the plan has been working to achieve the goals; adjust things that aren't working within the plan; and assign new tasks to team members. In the words of one reviewer of Youth and Family Engagement, "regardless of the outcome in terms of family reunification, the ICC made herculean efforts to engage all three potential family caregivers (with neutrality despite custody battles) as well as the foster family."*

7.3.C.3. Care Coordination and Care Management

LHBS will provide care coordination and care management services in accordance with all requirements of the model contract, as summarized in *Table 7.3-8*. LHBS believes that–as an organization–the key to providing effective care coordination and care management is to hire

the right staff and to train them well, to value communication and the exchange of information, and to establish a strong relationship with the enrollee.

1. **Leverage Our Experience.** Honing these skills takes experience, which LHBS can offer in abundance. LHBS provides care coordination services to children and adults today across a range of programs including ICC, CSP, ESP, HFY, and CHART. As a CBHI provider for almost a decade, we are experienced in ensuring that families and their children with significant behavioral, emotional, and mental health needs obtain the services necessary for success in home, school, and community. LHBS has developed an expertise in being able to identify all stakeholders who should be involved in the care coordination and care management process. LHBS will leverage this experience to: (1) identify all stakeholders who should be involved in the care coordination and care management process; (2) exchange information with all stakeholders; (3) identify and organize members of the enrollee's care team; and (4) ensure effective on-going communication across all stakeholders.
2. **Engage Our Enrollees.** As a CP, we will encourage enrollees to identify the key members of the care team, in addition to the required members of the Care Team as outlined in the contract. We will encourage the exchange of information by offering to attend meetings with the enrollees, and ensuring that their needs are met in a culturally and linguistically appropriate manner. We will remove any barriers to the exchange of information.
3. **Ensure On-Going Communication.** To ensure effective and on-going communication, we rely upon a variety of methods including engaging our multi-disciplinary teams in clinical rounds, requiring that care managers review every client in their caseload, and establishing interoperability of record systems. Furthermore, in the CP program we will expand this regular communication to include the member's PCP and other medical and social service providers. This routine communication will ensure our members' experience integrated, high-quality care while also preventing issues from falling through the cracks.
4. **Address LTSS Needs.** As a BH CP, we must ensure that we address the LTSS needs of our engaged enrollees. It is our understanding that nearly 60 percent of our assigned and engaged enrollees may have LTSS needs. It is critical that we go above and beyond the requirement to ensure that enrollees know that their choices are, that we provide enrollees with assistance in navigating and accessing needed LTSS and LTSS-related services, and that we identify LTSS providers that served or might serve the enrollee.
5. **Address the Social Determinants of Health.** As a BH CP, we must ensure that we address the underlying economic and social conditions facing our engaged enrollees. These themes feature prominently in our assessment form and will also be addressed regularly and comprehensively by our care managers working with members. We will use a screening tool specific to social determinants of health. LHBS will create a tool that leverages the types of questions that have been recommended by organizations with expertise in addressing these social and economic needs. We will leverage the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), and many questions that have been created by other states and organizations.

Table 7.3-8: Care Coordination and Care Management

#	CP Supports and Activities	Our Commitment to CP Goals and Contract Requirements	Our Approach for Meeting All Requirements with Evidence-Based, Emerging and Best Practices
3	Care Coordination and Care Management	LHBS intends to meet all contract requirements including: (1) form and operate a Care Team around the needs and preferences of the engaged enrollee (including provide encouragement to engaged enrollee to identify all care team member, assemble all required care team members); (2) facilitate communication with all including enrollee, PCP, and all other providers including RSNs, CBFS providers, LTSS providers, and other providers for the express purpose of promoting service delivery coordination and improved outcomes; and, (3) facilitate and coordinate LTSS services by informing engaged enrollees about his/her choice of specific LTSS services and programs and providers, assisting engaged enrollees, and identifying providers; and, (4) execute the activities necessary to support the engaged enrollee's person-centered Treatment Plan including ensuring that the engaged enrollee has timely and coordinated access to primary, medical specialty, LTSS and behavioral health care.	LHBS, learning from past experience, intends to implement a care management program that prioritizes member-centeredness, communication and strong trusting relationships.

7.3.C.4. Care Transitions

For persons with lived experience of SMI and/or SUD, all transitions of care are important: transitions to another provider, another PCP, to this new CP program, a move from one home to another or from one program to another or from one job to another or none, and finally, from community to hospital or hospital to community. LHBS will not focus exclusively on transitions of care from hospital to community, although these transitions of care are particularly critical to individuals with high BH needs.

Building on decades of experience as emergency service providers and inpatient psychiatric providers in the community, LHBS CP will provide a robust program of support for members who are hospitalized that starts from the moment they enter the facility. Leveraging our current presence within the emergency departments and inpatient units–both medical and psychiatric–LHBS CP staff will be aware of the admission and will communicate important clinical information that can improve care. We will be involved in every step of the discharge planning,

In coordination with the enrollee and all other stakeholders, including the PCP, ACO, MCO and family, and will ensure appropriate supportive services are in place prior to discharge.

We will also be there on the other side of the hospital and in the community to ensure that we support all types of care transitions. This includes a contact with the care manager within 48 hours of discharge and a home visit as needed. Following best practices for post-discharge engagement, LHBS care coordinators will re-confirm or update the treatment plan, review medications and confirm supports are in place. The RN will conduct medication reconciliation. If there has been a change in status, the care coordinator will arrange for a new assessment during that post-discharge contact to ensure the information and treatment plan are current.

Information gained from the post-discharge contact will be communicated to the PCP and other specialty providers including at follow-up visits.

LHBS will meet all requirements of the contract to ensure that our enrollees receive every form of assistance in our capacity as a CP to help the enrollee make a smooth transition back to the community. LHBS will satisfy all care transitions requirements in accordance with the model contract, and as summarized in *Table 7.3-9*. We will use evidence-based or emerging practices as appropriate. We will include all the necessary steps to ensure engaged enrollee's stability and satisfaction following a transition in care.

Table 7.3-9: Care Transitions

#	CP Supports and Activities	Our Commitment to CP Goals and Contract Requirements	Our Approach for Meeting All Requirements with Evidence-Based, Emerging and Best Practices
4	Care Transitions	LHBS intends to meet all contract requirements including: (1) assist in the development of a discharge plan; (2) ensure that the CP team is present at the discharge planning meetings; (3) ensure that follow up is provided within 3 business days of inpatient discharge and all minimum requirements are met including a face to face visit and updated person-centered Treatment Plan; (4) provide updates to enrollee's ACO or MCO: (5) assist engaged enrollees in accessing all supports.	LHBS will bring its experience with care transitions with our CSP and RSN meeting with members prior to discharge from Inpatient (IP) and Acute Treatment Services (ATS). LHBS will also bring its successful experience from CBHI, which involves meeting with their enrolled members prior to discharge from a 24-hour level of care.

7.3.C.5. Medication Reconciliation

LHBS will satisfy all medication reconciliation requirements in accordance with the contract, and as summarized on *Table 7.3-10* below, including meeting the requirement that a RN on the Care Team perform the medication reconciliation. Our plans to develop this program of medication reconciliation are based on the goal of developing "one source of truth." (Source: Agency for Healthcare Research and Quality (AHRQ).)

Table 7.3-10: Medication Reconciliation

#	CP Supports and Activities	Our Commitment to CP Goals and Contract Requirements	Our Approach for Meeting All Requirements with Evidence-Based, Emerging and Best Practices
5	Medication Reconciliation	LHBS intends to meet all contract requirements including: (1) ensure that medication reconciliation is performed by an RN on the Care Planning Team.	LHBS will bring its experience using technology to facilitate medication reconciliation in acute care settings to the more difficult, but equally, vital task of ensuring that each member's medication regimen is up to date at home and in community-based settings.

Medication reconciliation is a process to ensure that the latest medication regimen is communicated to and implemented in new settings. For example, when a member returns home from an acute care setting, it is vital that any discontinued medications are removed from the active medication list and any dosage changes are updated. The Lahey Health System hospitals have sophisticated medication reconciliation systems in place, facilitated by embedding in the electronic medical record. However, such systems are generally less routine and less refined in the community, where a patient may, for example, have medications changed by multiple outpatient providers and the patient may move between subacute care settings. LHBS will utilize both technology and clinical skill to make sure that members are on the correct medications as they make such transitions. The software we are evaluating will enable the LHBS CP to have for each member a list of medications that will be reconciled after each care transition and outpatient provider appointment. The RN will review the regimen for medication interactions and any other concerns. The RN will be supported by the CHW workforce who will be trained in collecting information from BH CP members on their medications.

In addition, LHBS will leverage well-established toolkits in medication reconciliation such as *Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation* that is comprehensive and recognizes the complexity of the reconciliation process. (Source: AHRQ.) MATCH provides a list of several effective strategies to use in creating a strong program of medication reconciliation including: (1) establish the process around the singular goal of "one source of truth," or the goal of generating an accurate list of medications; (2) ensure that this list is communicated to all relevant individuals; (3) create a person-centered process, involving the CP enrollee, and family members, as appropriate; (4) involve all relevant providers in the process; (5) communicate roles and responsibilities clearly; (6) integrate medication reconciliation into workflows; and, (7) design the process to account for the setting of care.

All LHBS protocols for member engagement will require addressing medications at all contacts, and especially during transitions. Care Coordinators will communicate about medications with PCPs, other medical and BH providers and additional appropriate stakeholders routinely via the Mass HiWay or other secure information sharing platform.

7.3.C.6. Health and Wellness Coaching

LHBS will satisfy all health and wellness coaching requirements in accordance with the contract, and as summarized on *Table 7.3-11* below. LHBS will develop procedures for conducting "Health and Wellness Coaching." These procedures will include: (1) programs of health and wellness education, coaching and health promotion that LHBS will utilize and follow; and, (2) methods for ensuring that engaged enrollee's goals for the health and wellness programs are recorded and tracked in the engaged enrollee's person-centered treatment plans. We provide health coaching through several of our programs today.

Under HFY, we provide health coaching and we track these health and medical outcomes through regular communication with PCPs, who are tracking the medical conditions and outcomes of our members. Our Care Coordinators are aware of the health issues, and medical needs, or our members. These health issues and related goals around health and wellness are

reflect in the care plans. Our Care Coordinators receive an overview of the following health conditions as a part of the onboarding training:

- Overview of Diabetes (Core)
- Heart Disease or Circulatory Disorder (Core)
- High Blood Pressure (Core)
- Sexually Transmitted Infections
- Cancer
- Lung Disease (asthma, COPD, etc.) (Core)
- Kidney Disease
- Stomach or Intestinal Disorder
- Liver Disease
- Seizure Disorders (Epilepsy)
- Traumatic Brain Injury/Head Injury
- D.T.s (Delirium Tremens)
- Headaches, Migraines
- Disability Overview: Memory, Visual and Hearing Impairment
- Tuberculosis
- Eating Disorder

Table 7.3-11: Health and Wellness Coaching

#	CP Supports and Activities	Our Commitment to CP Goals and Contract Requirements	Our Approach for Meeting All Requirements with Evidence-Based, Emerging and Best Practices
6	Health & Wellness Coaching	LHBS intends to meet all contract requirements including: conduct health and wellness coaching in accordance with the treatment plan.	LHBS will bring its experience and evidence-based practices in addressing health and wellness in a variety of our care management programs.

Plans to Connect Engaged Enrollees to Community and Social Services

LHBS has developed a robust plan to connect engaged enrollees to community and social services in accordance with the contract, and as summarized on *Table 7.3-12* below. Through this program, LHBS will have the opportunity to address the non-medical needs of our enrollees by creating connections to the community and social services.

Table 7.3-12: Connection to Community and Social Services

#	CP Supports and Activities	Our Commitment to CP Goals and Contract Requirements	Our Approach for Meeting All Requirements with Evidence-Based, Emerging and Best Practices
7	Connection to Community and Social Services	LHBS intends to meet all contract requirements including: assess engaged enrollee for community-based social and Flexible Services' needs using EOHHS-approved social services assessment tools; and, identify community-based, social and Flexible Services and resources to support the enrollee's health and well-being.	LHBS will bring its experience and evidence-based practices to create strong connections to community and social services for CP enrollees. LHBS current has long-standing relationships with stakeholders, social services in the communities we serve in all 9 services areas in the northeast region.

Given our rich history of community involvement, LHBS has developed a breadth of knowledge about community and social services, and understands the value of these services to healthcare access, use, and costs. We will build upon this experience for our BH CP members.

As a CP, LHBS will operate at the center of the system, with relationships with the clinical providers and community and social service providers to help members navigate the complex

system of healthcare, improve their experience and quality of life. We will do by investing DSRIP funds to build a stronger infrastructure, by collaborating across ACOs, MCOs, CPs, and community organizations to address the social determinants of health, and across delivery systems to deliver integrated care. Leveraging our experience, we will connect engaged enrollees to community and social services and establish a process that encompasses the following key components:

1. **Evaluate Engaged Enrollees with the Use of Screening Tool for Social Services.** LHBS will use a screening tool for social services that reflects emerging practices in screening of individuals covered under Medicaid. Across the country, there is a widespread focus on learning more about the individual needs across all domains of the social determinants of health. LHBS will create a tool that leverages the types of questions that have been recommended by organizations with expertise in addressing these social and economic needs. We will leverage the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), and many questions that have been created by other states and organizations.
2. **Hire and Develop Staff with Knowledge and "Know-How."** LHBS will hire staff that have the knowledge and "know how," and have a breadth of knowledge about social services and supports, and providers of these supports. We will hire people who bring with them a portfolio of knowledge about what exists within the communities in the Northeast region.
3. **Assist Enrollees in Accessing Services.** We will assist enrollees in any way possible by making referrals, by attending meetings, and by making recommendations about the use of Flexible Services.
4. **Develop an Inventory.** We will develop an inventory of social services and supports by provider, by community and by type of social service and support that is easy to use. We will ensure the breadth of programs and its accuracy and completeness through outreach to social service and support agencies across an array of needs. We will also notify organizations within all service areas to generate their interest in being listed.
5. **Collaborate with ACOs on Flexible Services and Outcomes.** LHBS will collaborate closely with ACOs to ensure that the use of DSRIP funds used on flexible services drive improved outcomes for engaged enrollees. We will work closely with ACOs to develop a framework for measuring outcomes that is data driven, and examines both cost outcomes from reducing emergency department visits, for example, and improving health based on both process and outcomes measures.
6. **Examine the Feasibility of a Financial Relationship.** LHBS will review the feasibility of establishing a financial relationship with organizations to facilitate a stronger and value-driven relationship.

7.3.C.7. Attachments for Section 7.3.C

7.3.C.7.1 *Implementation Workflow*

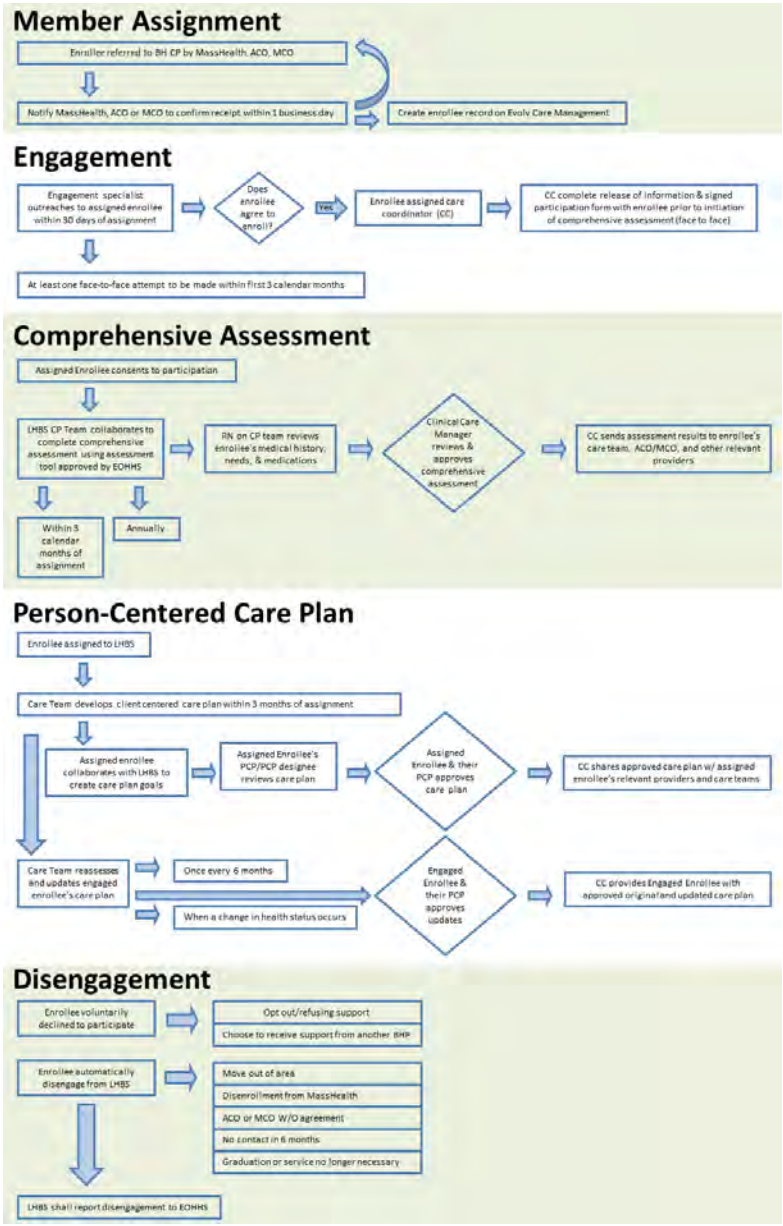


Figure 7.3-1: Implementation Workflow

7.3.C.7.2 *Comprehensive Assessment Tool*

Lahey Health
Behavioral Services

BHCP PERSON-CENTERED COMPREHENSIVE ASSESSMENT: ☐ Initial ☐ Annual

Client name:	Date this of this assessment Click here to enter a date.	Due Date of Reassessment	Click here to enter a date.
DOB Click here to enter a date.	ACO:	Service Area:	
Caregiver/Guardian (if applicable): ☐			

I. Immediate Care Needs

1.1 Why are you here? What do you hope to achieve?
(Use client quotes, include potential goals)
Click here to enter text.

II. Current Services

2.1 Do you have Behavioral Health Provider?	○ YES ○ NO
2.1a Name of Provider	Click here to enter text.
2.1b Most Recent visit	Click here to enter text.
2.1c Provider Phone	Click here to enter text.
2.1d Provider Address	Click here to enter text.

2.2 Currently receiving services from a state agency:	
☐None	☐DCF was DSS
☐DYS youth services	☐DMH
☐DDS was DMR	☐DPH
☐DTA	☐MRC Mass Rehab
☐Commission for Blind	☐MCDHH Deaf
☐Other:	If other, explain: Click here to enter text.

III. MEDICAL HISTORY

3.1 Do you have Primary Care Physician?	○ YES ○ NO
3.1a Name of Primary Care Physician	Click here to enter text.
3.1b Most Recent Physical	Click here to enter text.
3.1c PCP Phone	Click here to enter text.
3.1d PCP Address	Click here to enter text.

3.2 Other Healthcare Treatment Providers	Name	Type of Provider	Phone
	Click here to enter text.	Choose an item.	Click here to enter text.
	Click here to enter text.	Choose an item.	Click here to enter text.
	Click here to enter text.	Choose an item.	Click here to enter text.
	Click here to enter text.	Choose an item.	Click here to enter text.

3.3 Check all that apply. ☐ No updates since last assessment							
Past	**Current**	**Family**		**Past**	**Current**	**Family**	
☐	☐	☐	Heart Disease or Circulatory Disorder	☐	☐	☐	Walking Problems or Poor Balance
☐	☐	☐	High Blood Pressure	☐	☐	☐	Numbness, Tingling of Extremities
☐	☐	☐	Bleeding	☐	☐	☐	Diabetes
☐	☐	☐	Anemia	☐	☐	☐	Menstruation Problems
☐	☐	☐	Lung Disease (asthma, COPD, etc.)	☐	☐	☐	Breast Problems
☐	☐	☐	☐Kidney Disease	☐	☐	☐	Genitalia Problems
☐	☐	☐	Stomach or Intestinal Disorder	☐	☐	☐	Bone Disease
☐	☐	☐	Liver Disease	☐	☐	☐	Cancer
☐	☐	☐	Sexually Transmitted Disease *If past/current –provide more details* Click here to enter text.	☐	☐	☐	Tuberculosis Date of last test: Click here to enter a date. *Results:* ☐positive ☐negative
☐	☐	☐	D.T.s (Delirium Tremens)	☐	☐	☐	Seizure Disorders (Epilepsy)
☐	☐	☐	Traumatic Brain Injury / Head Injury	☐	☐	☐	Surgery
☐	☐	☐	Headaches, Migraine	☐	☐	☐	Dizziness/Fainting/Loss of Consciousness
☐	☐	☐	Memory Problems	☐	☐	☐	Eating disorder
☐	☐	☐	Visual Problems	☐	☐	☐	Other, List below:
☐	☐	☐	Hearing Problems			☐	

3.4 Is the member taking blood thinners?	○ YES ○ NO

3.5 Would any of the above impact your ability to participate in treatment?		
Click here to enter text.		
3.6 Allergies (include reaction(s):		
3.6a Medication Allergies ○ YES ○ NO	**7.9b Food Allergies** ○ YES ○ NO	**7.9c Environmental Allergies** ○ YES ○ NO
If Yes, list medication allergies	*If Yes, list food allergies*	*If Yes, list environmental allergies*
Click here to enter text.	Click here to enter text.	Click here to enter text.

3.7 Physical Health Areas of Focus: (For Conditions identified on the Physical Health Assessment, which is of most concern to the member?)
Click here to enter text.

IV. MEDICATION

4.1 Medications ☐None Reported ☐No updates since last assessment		
Medication	**Purpose**	**Self-reported Effectiveness**
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.

Click here to enter text.	Click here to enter text.	Click here to enter text.

V. Functional/ADL ASSESSEMENT

Are you able to independently:	
5.1 Use a phone, dial numbers, answer calls?	○ YES ○ NO
5.2 Shop for any food or other items you need?	○ YES ○ NO
5.3 Plan, prepare and serve adequate meals?	○ YES ○ NO
5.4 Take care of housekeeping/cleaning?	○ YES ○ NO
5.5. Take care of laundry and dress in clean clothes every day?	○ YES ○ NO
5.6 Travel to your appointments or other places you want to go?	○ YES ○ NO
5.7 Take medications in the correct dosages at the correct time?	○ YES ○ NO
5.8 Handle your finances, pay bills, track your income, and use a bank?	○ YES ○ NO

VI. Strengths/Care Goals

6.1 What are your personal strengths?
Click here to enter text.
6.2 What are your needs and challenges (Include disability needs, assisted technology, social supports, referrals, collateral input)
Click here to enter text.
6.3 What are some interest abilities, talents or things you are good at?
Click here to enter text.
6.4 What are your care goals?
Click here to enter text.
6.5 What are your personal goals?
Click here to enter text.

VII. MENTAL HEALTH TREATMENT HISTORY

7.1 Any prior admissions to each mental health treatment modality: ☐ No History ☐ No updates since last assessment			
# Counseling	Choose an item.	**# Partial Hospitalization**	Choose an item.
# Inpatient	Choose an item.	**# IOP**	Choose an item.
# CCS	Choose an item.	**# Residential**	Choose an item.

7.2 Most recent 3 Psychiatric Hospitalizations ☐ None Reported ☐ No updates since last assessment		
Date(s)	**Provider(s)/Location(s)/Contact(s)**	**Comment(s)**
	Click here to enter text.	Click here to enter text.
	Click here to enter text.	Click here to enter text.

	Click here to enter text.	Click here to enter text.

VIII. SUBSTANCE USE TREATMENT HISTORY

8.1 Any prior admissions to each substance use treatment modality: ☐ No History ☐ No updates since last assessment			
# Detox	Choose an item.	**# Impaired Driver**	Choose an item.
# Residential	Choose an item.	**# Opioid/MAT**	Choose an item.
# Section 35	Choose an item.	**# Other**	Choose an item.

8.2 Overdose History:	○ YES ○ NO	*If yes, completed the remainder of the table*
8.2a	Substance related	○ YES ○ NO
8.2b	Other	○ YES ○ NO
8.2c	Most Recent	Click here to enter text.
8.2d	Total #	Choose an item.

IX. ACCESSIBILITY REQUIREMENT-

9.1 Transportation	Click here to enter text.
9.2 Communication Needs	Click here to enter text.
9.3 Equipment needs	Click here to enter text.

X. HOUSING/HOME ENVIRONMENT

☐ **No updates since last assessment**

10.1 Marital Status:	Choose an item.	
10.2 Do you consider yourself to be:	Choose an item.	
	If other, explain:	Click here to enter text.
10.3 Where do you usually live? *(Where has the client spent/slept most of the time over the last 12 months?)*	Choose an item.	
10.4 Do you feel safe in your home?	○ YES ○ NO	
	If No, please explain Click here to enter text.	
10.5 Are you at risk of losing housing?	○ YES ○ NO	
	If Yes, please explain Click here to enter text.	

10.6 Do you have children?	○ YES ○ NO	*If yes, complete the following question:*	
10.6a Number of children:	**# 0- 6 Years old**	Choose an item.	
	# 6-18 years old	Choose an item.	
	# Over 18 years old	Choose an item.	

10.6b How many of your children live with you?	Click here to enter text.

10.7 Who else lives with you? *Check all that apply*	
☐ alone	☐spouse/equivalent
☐ child under 6	☐parent(s)
☐child 6-18	☐other relative
☐child over 18	☐friend/roommate

10.8 Does anyone in your home use/misuse alcohol, nicotine or other drugs?	○ YES ○ NO
If yes, please explain	
Click here to enter text.	

10.9 Current Living Stressors (*Check all that apply*): ☐ No updates since last assessment	
☐ Marital Issues ☐ Presence of Substance Use ☐ Caretaking Pressures ☐ Safety in Home	☐Custody Issues ☐Safety of Neighborhood ☐Homeless or at risk of losing ☐Chronic/Terminal Disease
☐ employment	☐ financial
☐ legal	☐ family issues
☐None	☐ Other: If other, explain: Click here to enter text.

10.10 Sources of Support (*Check all that apply*): ☐ No updates since last assessment	
☐Children	☐Spouse/Significant Other
☐Sibling	☐Parent
☐Other Family	☐Co-Worker
☐Self-Help/Peer Support Groups	☐Physician
☐Spiritual/Religious/Church	☐Work
☐Friends/Neighbors	☐Probation
☐Community/Group/Agency	☐School
☐CBHI services	☐None
☐Other:	If other, explain: Click here to enter text.

10.11 Are you involved in any religious, spiritual or cultural activities?	○ YES ○ NO
If Yes, please explain:	
Click here to enter text.	

XI. EDUCATION AND EMPLOYMENT STATUS

☐ **No updates since last assessment**

11.1 Highest level of education:	Choose an item.
11.2 Have you ever served in the military?	☐ No ☐ Yes

11.3 Currently employed:	☐ No ☐ Yes
	If yes, where: Click here to enter text.
11.4 Profession:	Click here to enter text.
11.5 How long employed in current job:	Choose an item.

11.6. What are your professional interests/goals?
Click here to enter text.

11.7. What are some leisure activities that you have?
Click here to enter text.

XII. LEGAL STATUS

☐ None reported ☐ No updates since last assessment

Legal Issue	Past	Present	Related to substance use	Comments
12.1 Custody dispute	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	Click here to enter text.
12.2 Probation	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	Click here to enter text.
12.3 Parole	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	Click here to enter text.
12.4 Open court case	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	Click here to enter text.
12.5 Warrant	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	Click here to enter text.
12.6 Arrests	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	Click here to enter text.
12.7 Convictions	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	Click here to enter text.
12.8 Incarceration	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	Click here to enter text.
12.9 Registered sex offender	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	Click here to enter text.
Comments: Click here to enter text.				

XIII. INCOME/FINANCIAL SUPPORT

13.1 Income Source:	Choose an item.

XIV. SOCIAL SUPPORTS

14.1 Sources of Support (*Check all that apply*): ☐ No updates since last assessment

☐ Children	☐ Spouse/Significant Other
☐ Sibling	☐ Parent
☐ Other Family	☐ Co-Worker
☐ Self-Help/Peer Support Groups	☐ Physician
☐ Spiritual/Religious/Church	☐ Work
☐ Friends/Neighbors	☐ Probation
☐ Community/Group/Agency	☐ School
☐ CBHI services	☐ None
☐ Other:	If other, explain: Click here to enter text.

14.2 Are you involved in any religious, spiritual or cultural activities?	○ YES ○ NO
If Yes, please explain:	
Click here to enter text.	

XV. RISK FACTORS

15.1 Have you ever been exposed to *(Check all that apply)*: ☐ None Reported ☐ No updates since last assessment

☐ serious accident	☐ domestic violence	☐ assault	☐ sexual abuse as child/youth
☐ natural disaster	☐ homelessness	☐ war/military duty	☐ physical abuse as child/youth
☐ sexual assault	☐ significant loss or death	☐ history of foster care	☐ verbal abuse
☐ witness to violence	☐ victim/witness to terror attack	☐ other: Click here to enter text.	

COMMENTS:
Click here to enter text.

15.2 Have you had thoughts of hurting yourself ?	○ YES ○ NO	*If yes, complete the following two (2) questions*
15.2a	Most Recent	Click here to enter text.
15.2b	Total #	Choose an item.
15.2c	Please Explain	Click here to enter text.
15.2c Have you followed through on these thoughts	○ YES ○ NO	*If yes, complete the following two (2) questions*
15.2d	Most Recent	Click here to enter text.
15.2e	Please Explain	Click here to enter text.

15.3 Have you had thoughts of hurting others?	○ YES ○ NO	*If yes, complete the remainder of the table*
15.3a	Most Recent	Click here to enter text.
15.3b	Please Explain	Click here to enter text.
15.3c Have you followed through on these thoughts?	○ YES ○ NO	*If yes, complete the remainder of the table*
15.3d	Most Recent	Click here to enter text.
15.3e	Please Explain	Click here to enter text.

15.4 Was safety plan completed?	○ YES ○ NO	*If no, please explain*
	Explain:	Click here to enter text.

15.5 Do you sometimes drink beer, wine or other alcoholic beverages?		○ YES ○ NO *If yes, complete the remainder of the table*
15.5a	How many times in the past year have you had 5 of more drinks (4 or more for women and men over 65) in a day?	Choose an item.
15.5b	On average, how many days a week do you have an alcoholic drink?	Choose an item.
15.5c	On a typical drinking day how many drinks do you have?	Choose an item.

15.6 How many times in the past year have you used an illegal drug or prescription medication for non-medical reason? *(If asked what a non-medical reasons means you can say because of the experience or feeling the drug caused.)*	Choose an item.

15.7 History Substance Mis-use, Nicotine/Tobacco Use *For pharmaceutical drugs prescribed for the client, only code misuse (more than the recommended dosage) or non-medical use. (Example - If the client was prescribed a benzodiazepine for a mental health disorder and used per instruction, do not list on History Table.)* *Note: For the safety of the client all drugs used must be recorded in the client record.*		Have You Ever Mis-Used		Age of First Use	*Last Use	**Freq of Last Use	***Route of Admin Code
		Y	N	Codes for these below this table			
A	**Alcohol** *For Alcohol, enter first age of intoxication:*						
B	**Cocaine**						
C	**Crack**						
D	**Marijuana / Hashish**						
E	**Heroin**						
F	**Prescribed Opiates** *Misuse/non-medical use of pharmaceutical opiates which were prescribed for the client.*						
G	**Non-prescribed Opiates** *Non-medical use of pharmaceutical opiates which were not prescribed for the client*						
H	**PCP**						
I	**Other Hallucinogens**						
J	**Methamphetamine**						
K	**Other Amphetamines**						
L	**Other Stimulants**						
M	**Benzodiazepines**						
N	**Other Tranquillizers**						
O	**Barbiturates**						
P	**Other Sedatives / Hypnotics**						
Q	**Inhalants**						
R	**Over the Counter**						
S	**Club Drugs**						
T	**Other**						
U	**Nicotine/Tobacco** *Includes cigarettes, cigars, chewing tobacco, inhalers*						

*Code	Last Use Substances
1	12 or more months ago
2	3-11 months ago
3	1-2 months ago
4	Past 30 days
5	Used in last week

**Code	Frequency of Last Use
1	Less than once a month
2	1-3 times a month
3	1-2 times a week
4	3-6 times a week
5	Daily
99	Unknown

***Code	Route of Administration
1	Oral (swallow and/or chewing)
2	Smoking
3	Inhalation
4	Injection
5	Other

15.8 Number of cigarettes currently smoked per day. *(Indicate number of cigarettes, not number of packs: 1 pack = 20 cigarettes* *If client uses another type of nicotine/tobacco product, mark Zero (0).*	Choose an item.
15.9 Have you had periods of recovery? When, and what was helpful during that time?	
Click here to enter text.	

XVI. HEALTH AND WELLNESS

16.1 Do you have enough food to eat?	○ YES ○ NO
16.2 Where do you shop for food?	Click here to enter text.
16.3 Do you have SNAP benefits?	○ YES ○ NO
16.4a If you run out of food, do you know where to find free meals or emergency food boxes?	○ YES ○ NO
16.4b Food Secure:	○ YES ○ NO
16.5 Do you exercise regularly?	○ YES ○ NO

XVII. GUARDIANSHIP

17.1. Is client own Legal Guardian?	○ YES ○ NO				
Guardian Name	**First Name:**	Click here to enter text.	**Last Name:**	Click here to enter text.	
Address 1	Click here to enter text.				
Address 2	Click here to enter text.				
City	Click here to enter text.	**State**	Click here to enter text.	**Zip Code**	Click here to enter text.
Home Phone	Click here to enter text.				
Mobile Phone	Click here to enter text.				
Email	Click here to enter text.				

XVIII. ADVANCE HEALTH CARE DIRECTIVES

18.1. Do have a designee as an agent to make health care decisions for you in the event that you cannot: ○ YES ○ NO			
First Name:	Click here to enter text.	**Last Name:**	Click here to enter text.
Relationship	Click here to enter text.		
Address 1	Click here to enter text.		
Address 2	Click here to enter text.		

City	Click here to enter text.	State	Click here to enter text.	Zip Code	Click here to enter text.
Home Phone	Click here to enter text.				
Mobile Phone	Click here to enter text.				
Email	Click here to enter text.				

18.2 Do you have an advanced health care directives	○ YES ○ NO *If Yes, please explain:*
Click here to enter text.	

XIX. ACUTE CARE PLANS

19.1 Do you Have a behavioral health Acute care plan?	○ YES ○ NO
If Yes, please explain:	
Click here to enter text.	

19.2 Do you have a medical acute care plan?	○ YES ○ NO
If Yes, please explain:	
Click here to enter text.	

XX. Assessment Summary

Briefly describe identifying information, presenting problem, recent events or psychological difficulties, any barriers. Reflect motivation, readiness for change, support systems, and other resources that can aid the client. What is the immediate recommendations and goals?

Click here to enter text.

XXI. SIGNATURES:

Client's Signature:	Date: Click here to enter a date.	Registered Nurse (if applicable): ☐ N/A	Date: Click here to enter a date.
Care Coordinator Signature:	Date: Click here to enter a date.	Clinical Care Manager:	Date: Click here to enter a date.

Lahey Health
Behavioral Services **BHCP PERSON-CENTERED CARE PLAN:** ☐ **Initial** ☐ **6 months Reassessment** ☐ **Status Change**

Client name:	**Date this plan** Click here to enter a date.	**Due Date of Reassessment**	Click here to enter a date.
DOB Click here to enter a date.	**ACO:**	**Service Area:**	
Caregiver/Guardian (if applicable): ☐			
Statement of Problem/Desired Outcome in client's own words:			
Comprehensive Assessment Summary			
Flexible services (Check all that apply)			
☐ Flexible Services ☐ Flexible Services ☐ Flexible Services ☐ Flexible Services ☐ Flexible Services ☐ Flexible Services ☐ Flexible Services ☐ Flexible Services ☐ Flexible Services ☐ Flexible Services ☐ Flexible Services ☐ Flexible Services			

Care Team Participants

Role	Name	Agency	Phone Check (√) Preferred method of contact	Email Check (√) Preferred method of connect
PCP or Designee			☐ 111-22-1234	☐ First Last @example.com
Clinical Care manager			☐ 111-22-1234	☐ First Last @example.com
Care Coordinator			☐ 111-22-1234	☐ First Last @example.com
Behavioral Health Clinician			☐ 111-22-1234	☐ First Last @example.com
Family Members			☐ 111-22-1234	☐ First Last @example.com
Specialist			☐ 111-22-1234	☐ First Last @example.com
Other : (Care giver/Advocate/state agency)			☐ 111-22-1234	☐ First Last @example.com

Current Services (Behavioral health and Medical)

Service Type	Frequency	Duration
Outpatient	Weekly	9months

PCP/Specialist		

Summarize how the services and care will be integrated and coordinated among health care providers:

Long Term Treatment Goal:
Goal 1:
Goal : 2
Short Term Treatment Goal:
Goal 1:
Goal 2:

Objective(s): Steps towards goal that client will take; In their own words written in *measurable & observable* terms
Describe how goals will reduce risk and help manage the complexity of member's health conditions

Goal 1:
Goal 2:

Intervention(s): Steps/actions provider will take to support client in reaching goal/objectives	Service/ Modality	Frequency	Responsible Party (If appropriate)
Goal 1:			
Goal 2:			

Progress Towards goal:	
Progress Since Last care Plan:	Goal 1: ☐ **Problem Resolved/ Goal Met** ☐ **N/A : Initial Tx Plan/New Problem**
Progress Since Last care Plan:	Goal 2: ☐ **Problem Resolved/ Goal Met** ☐ **N/A : Initial Tx Plan/New Problem**

Identified Barriers related to Each goal:

Crisis Plan Complete with Input from Behavioral Health Provider (If applicable)
Events that are Stressful For Me
Click here to enter text.
Signs That I am Having Difficulty: (Isolating? Using drugs/drinking? Self-harm behaviors? Crying? Feeling numb? Changes in sleep? Changes in appetite? Missing appointments? Not keeping to daily routine? Other?)
Click here to enter text.
Things That Calm Me: (Some ideas: hot bath or shower, exercise, deep breathing, guided imagery/ relaxation exercises)
Click here to enter text.
Things That Have not worked in the Past:
Click here to enter text.
Supports I can Call (Family, Friend, Sponsor/Name and Phone Number):
Click here to enter text.
Local Emergency Services Provider (Name and Phone Number):
Click here to enter text.
Name and Number of Therapist (to be reached during normal hours):
Click here to enter text.

☐ Transition Process/Aftercare Plans:	Anticipated Discharge Date:
Was the client provided a copy of the care Plan? ☐ Yes ☐ Offered & declined ☐ No, Reason:	

Client's Signature:	Date:	Supervisor Signature/Credentials (if applicable): ☐ N/A	Date:
Care Coordinator Signature	Date:	PCP/PCP designee Signature (if applicable): ☐ N/A	Date:

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7.3.D. Innovative Technologies for Service Delivery

Under the CHART and HFY programs, LHBS uses many innovative technological tools, which we will use as a BH CP. In addition, we will build a geo-mapping resource finder. See *Table 7.3-13* below for a summary of these tools.

Table 7.3-13: Summary of Technological Tools Used Currently and Future Use Plans

	Technological Tools	HFY/CHART	BH CP
1	Care management software: Use to match patients to intervention programs designed to proactively drive improved clinical outcomes and lower costs.	X	X
2	Telehealth: Use VIDYO, a secured teleconferencing application, for the facilitation of tele-psychiatry services in the ED.	X	X
3	Laptops and tablets: Use to communicate with clients. *	X	X
4	Smartphones: Use for communication. *	X	X
5	Innovative applications: Use as care extenders	X	X
6	Video Remote Interpretation: Use CyraCom to communicate with clients; CyraCom provides language interpretation and translation services.	X	X
7	Geo-mapping Resource Finder: Use for locating resources, community programs and services mapped to a client's geographic location. Examples of services that would be included in this resource finder include, but are not limited to, self-help group locations, food assistance, and cooking classes for individuals with eating disorders.		X
	* Technological Tools: *Each of our CHART and Here For You team members have been equipped with laptops, mobile internet hotspot capability, and smartphones. We will equip care coordinators in the same manner under the BH CP program.*		

Use of Technological Tools to Support Clients

Under CHART specifically, we use a care management application**,** VIDYO - a secured teleconferencing application, for the facilitation of tele-psychiatry services in the ED; and GoToMeeting Web-Based to broadcast the view of our host computer from our main Program Management Office (PMO) to a group of computers connected to the host computer through the internet. Under CHART and HFY, we use Smartphones to support connections to social supports for our clients; CyraCom for video remote interpretation services, when needed; and, we use many mobile applications to support clients, including the Department of Transitional Assistance (DTA) Application to facilitate the application for job, cash and food assistance; the Social Security Administration Application to facilitate the application for benefits; the Monitoring High Blood Pressures Application to support blood pressure monitoring; the Managing Nutrition Application **(**Calorie Counter and Food Diary can be downloaded at no cost). We are also piloting an enhanced patient engagement initiative with care coordinators using a tablet. In the future, we will develop a Geo-Mapping Resource Finder, or a comprehensive listing of resources, community programs and services that is geographically mapped to a client's location and filter by their needs.

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7.3.E. Personnel and Staffing

LHBS has a current workforce of 1,400 employees; nearly **40 percent of our workforce is an ethnic minority**, many have lived experience of SMI and/or SUD, and our care coordinators are bicultural and bilingual. We are very proud of our diverse and experienced workforce and look forward to building the same for the BH CP program.

LHBS has developed a Staffing Plan that will meet all responsibilities of the Contractor including all CP supports, as well as administrative aspects of the contact. This Staffing Plan is comprehensive of all elements including an Organizational Chart, a sample staffing model, recruitment plans including plans to recruit and hire staff from the cultural and linguistic communities that we will serve, training and orientation plans and modules, and strategies to retain staff.

As a CP, we know that building a strong CP program is nearly 100 percent dependent upon the staff whom we hire to provide the required supports, and then to go above and beyond those requirements. We will seek out staff with a positive attitude towards accomplishing the goals of the CP program and carry out the responsibilities despite the hard work and the challenges. (Source: SAMHSA, 2017.) We will hire staff from a diversity of backgrounds with connections to the community (Source: CHCS, 2017). And most importantly, we will hire staff who will advance our values of community first, SAMHSA recovery principles and cultural competence, all values that we live by today.

In fulfillment of this RFR requirements, see also: (1) *Section 7.3.E.2.1*: LHBS CP Organizational Chart; (2) *Table 7.3-15*: LHBS Sample Staffing Model and, (3) *Section 7.2.B.4.2*: LHBS Job Descriptions.

7.3.E.1. Organizational Chart

As the organization chart provided in *Section 7.3.E.2.1* demonstrates, LHBS has created an organization that reflects the structure and staffing required to achieve a level of excellence in our management and delivery of CP supports and activities to eligible CP enrollees covered under MassHealth and enrolled in an ACO program.

Sample Staffing Model

The LHBS' proposed staffing model is based upon three key assumptions, including: (1) that we must hire a diversity of staff in terms of skills and background, including cultural and linguistic backgrounds, to achieve our goals around quality and to recognize the degree of work involved; (2) that we must establish ratios of staff to enrollees that are effective; and, (3) that we clearly define roles and responsibilities for this staffing model.

LHBS has proposed a staffing model based on our understanding of the needs of the population today. We will review this staffing model as we move forward with implementation to ensure that we have an adequate balance of clinical staff and CHWs and to ensure that one RN is sufficient for our expected enrollment.

We have established a ratio of one care coordinator to every 40 BH CP enrollees, based upon our experience in other programs. We believe that a 1:40 ratio can best be met through a combination of eight Lead CHWs with a staffing ratio of 1:20, and 36 CHWs with a 1:40 staffing ratio. Together, these staff will offer a 1:40 staffing for 1,600 CP enrollees. This will create a

supportive environment for CHWs, prevent "burn out," and promote a career path by establishing Lead CHW positions. CHW teams will be located in geographically similar areas to the extent possible to support cross-sharing of local resources and learnings.

Table 7.3-15 below shows staff will support enrollees across service areas.

Table 7.3-15: Proposed Staffing Ratio By Service Area

	1	2	3	4	5	6	7	8	9	
	Beverly	Gloucester	Haverhill	Lawrence	Lowell	Lynn	Malden	Salem	Woburn	Total
Potential Assigned & Engaged Enrollees: #	*250*	*100*	*200*	*200*	*200*	*100*	*100*	*200*	*250*	*1,600*
Percent by Service Area:	*16%*	*6%*	*13%*	*13%*	*13%*	*6%*	*6%*	*13%*	*16%*	*100%*
Behavioral Health CP Director	0.16	0.06	0.13	0.13	0.13	0.06	0.06	0.13	0.16	**1**
Lead Community Health Worker	1.25	0.5	1	1	1	0.5	0.5	1	1.25	**8**
Caseload for Lead CHWs	25	10	20	20	20	10	10	20	25	160
Caseload for CHWs	225	90	180	180	180	90	90	180	225	1,440
CHWs	5.63	2.25	4.5	4.5	4.5	2.25	2.25	4.5	5.63	**36**
Sum Lead CWHs & CHWs	6.88	2.75	5.5	5.5	5.5	2.75	2.75	5.5	6.88	44
LICSW/LMHC	0.64 ~~16~~	0.24 ~~06~~	0.52 ~~13~~	0.52 ~~13~~	0.52 ~~13~~	0.24 ~~06~~	0.24 ~~06~~	052. ~~1~~3	0.64 ~~16~~	**41** ~~**1**~~
Engagement Specialist	0.16	0.06	0.13	0.13	0.13	0.06	0.06	0.13	0.16	**1**
Registered Nurse	0.96 ~~16~~	0.36 ~~06~~	0.78 ~~13~~	0.78 ~~13~~	0.78 ~~13~~	0.36 ~~06~~	0.36 ~~06~~	0.78 ~~13~~	0.96 ~~16~~	**61** ~~**1**~~
All BH CP Staff	**8.5**	**3**	**6.9**	**6.9**	**6.9**	**3**	**3**	**6.9**	**8.5**	**5648**

Recruitment Plans

LHBS has developed an effective Recruitment Plan that we believe will also lead to high rates of performance and high rates of retention. Upon notification of the award, LHBS' Human Resources Department will kick off our Recruitment Plan for this new program.

We have adopted many effective strategies to start up new and innovative programs such as CBHI, HFY and the CHART grant program, three successful programs whom success is highly related to the staff performing the jobs. As an organization, we are not only proud of the track record of our Human Resources Department in bringing the right people to the roles of care coordinators and care managers, but the collectivist culture that we have developed that is essential to retaining well-qualified staff. We do everything we can to provide a supportive environment through learning collaboratives. However, it must be said that being a CHW is a demanding job. On the positive side, we often see, given the age and interests of our staff, CHWs move on from LHBS to pursue a master's level program and promotional opportunities, which is why we have created eight Lead CHW positions.

LHBS utilizes many of the best practices for recruitment as set forth in the Toolkit's CHW Program Functionality Matrix, which is to recruit CHWs from "within the community through

community participation, meeting all selection criteria when possible." (Source: Recruitment of Community Health Workers, 2013.)

Our plan includes the following two key components:

Engage Human Resources. We have a strong Human Resources Department that we will leverage to hire the right people for this new program, in the face of a competitive environment where many other organizations are already seeking to recruit a strong CHW workforce. We have already enlisted our human resources staff to develop a timeline to recruit positions based on the position and job requirements.

Leverage our portfolio of recruitment strategies, including: (1) attending career and job fairs in the spring and fall in a variety of location in Massachusetts and in New Hampshire; (2) utilizing employee referral bonus program, including sign-on bonuses; (3) developing marketing materials through Lahey Health's contract with TMP Worldwide, a marketing firm. TMP also assists us with targeted recruitment strategies including direct mail, open house advertising, etc. We have a regular presence in the following media, including: Indeed, Glassdoor, LinkedIn, and Direct Employers Association, which offers postings to many diverse websites; and, (4) leveraging our internship program. This year alone we brought in 100+ interns into various programs. We have a Director of Student Internship Training to coordinate all interns through LHBS and to support our practice of aggressively recruiting interns upon graduation. We strongly believe that this is a key strategy for work force development.

LHBS will be ready for 1,000 enrollees on Day 1. Additional details of our recruitment plan include ramping up to support our growth trajectory of 1,600 BH CP enrollees by month four, or by September ~~July~~ 2018. See *Figures 7.3-2* and *7.3-3* for a look at the enrollment targets by month, and goals for hiring staff.

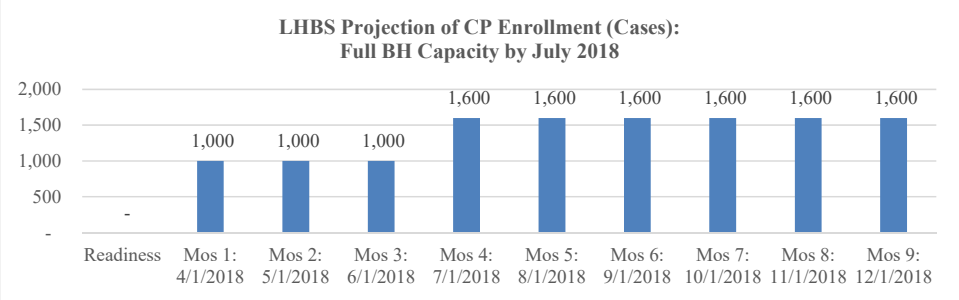

Figure 7.3-2: Enrollment Targets

This will be modified to reflect the June 1, 2018 start date. June will be Mos. 1

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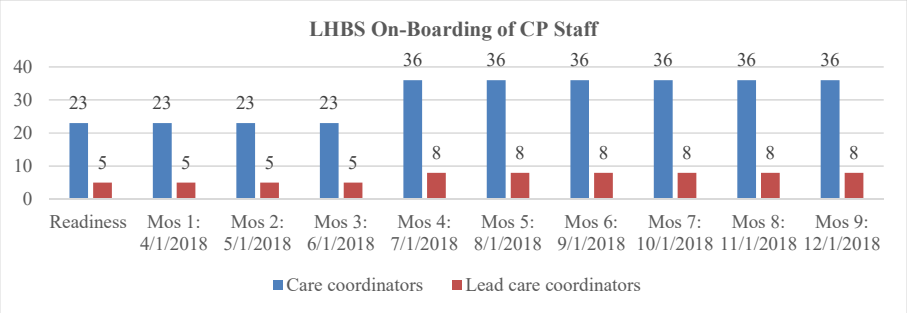

Figure 7.3-3: LHBS On-Boarding of CP Staff

This will be modified to reflect the June 1, 2018 start date. June will be Mos. 1

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Highlight on LHBS Plans to Retain CHART Community Health Workers*: CHWs are the bedrock of many of our programs. We will be able to "hit the ground running" on Day One because we will retain our CHWs who currently work in the CHART program when the CHART program ends on December 2017. They are excellent, well-trained, experienced CHWs, who are both bilingual and bicultural, and are ready to become our Lead Care Coordinators.*

Hiring and Recruitment: Cultural and Linguistic

Cultural and linguistic competency is critically important for individuals with high BH needs and need this level of competency throughout all CP supports and activities without which communication barriers would take hold. LHBS will ensure that our BH CP enrollees receive access to culturally and linguistically competent CP supports and activities. We are eager to collect more statistics on our BH CP enrollees to ensure that our hiring and recruitment process is as effective as possible. We have been successful in our current recruitment strategies. Our current staff of Care Coordinators are bicultural and bilingual, speaking German, Spanish, French, Portuguese, and Cape Verdean Creole. We also have a staff that includes many persons with lived experience of SMI and/or SUD.

For the BH CP program, LHBS will recruit and hire from the cultural and linguistic communities of our enrollees.

Training, Orientation Plans and Modules for Staff

LHBS intends to leverage and enhance our current training programs, orientation plans, and modules for Care Coordinators. But we will also enhance these programs to reflect the exciting development of a new payment and care delivery system under DSRIP that now includes CPs and the opportunities that come along with this new program. This includes additional training on medical care management, medication reconciliation, health and wellness coaching, the

identification and provision of flexible services, post-discharge follow-up, using the EHR and all protocols and workflows.

LHBS uses a care planning and care coordination curriculum that was developed by a social worker at the LHBS Program Management Office to: (1) standardize competencies; (2) provide staff with core skills to perform their responsibilities effectively; (3) promote staff professional growth; and (4) have on-going learning collaborative throughout the life of the program. This training curriculum uses best practices in the BH field Care Coordination Model and Adapted Competencies from the Massachusetts Board of Certification of Community Health Workers and incorporates other research from:

- Health Research and Services Administration (HRSA) Community Health Workers Evidenced-Based Models Toolbox
- Community Health Worker Initiative of Boston
- Arizona Area Health Education Centers Program's Community Health Worker National Education Collaborative

The core competencies curriculum (part of orientation) is covered over the course of two days and the remaining topics throughout the year at team meetings and monthly learning collaborative. Each session focuses on a specific training competency. The training emphasizes skills and tools necessary to engage with complex members including individuals with lived experience of SMI and SUD as well as complex medical co-morbidities and social determinants. The core competencies are led mainly by LHBS medical and behavioral health experts, as well other subject matter experts, experienced managers or program coordinators in the Commonwealth. The training is delivered primarily in person, and uses various learning approaches, including didactic lectures, as well as active learning techniques involving role playing, skits, brainstorming sessions, problem-solving games, and small group discussions.

Our current training programs for Care Managers and Care Coordinators is five full days. The five days include a combination of training and shadowing of a Senior Care Coordinator to ensure that care coordinator is ready to manage clients. Upon hire, the care coordinator attends the LHBS all-day organization orientation. The remaining four days are designed to orient the new staff person to program model and provide the tools, resources, knowledge and skills needed to provide care coordination to the target population. The training was created with the success of the care plan in mind as the frontline public health worker will interact with the client on a regular basis.

Staff Retention Strategy

LHBS has developed–and relied upon for years now–a strategy for staff retention that is fundamentally tied back to hiring the right people. At LHBS, however, we know that we must do our part to facilitate success:

1. **Collectivist Culture.** LHBS works hard to create a culture that promotes the sharing of values and resources. This culture of "we" has many beneficial effects on the LHBS organization and workforce including creating buffers again isolation, depression, and frustration.

2. **On-Going Training and Learning.** LHBS offers on-going training and support; our support for our staff is not limited to the on-boarding process. For example, we provide and encourage staff to participate in monthly Learning Collaboratives with peers.
3. **Remunerative Benefits.** Finally, LHBS is committed to offering our staff competitive salaries and benefits. Our health care benefit is based upon a tiered system, with varying levels of cost discounts within certain tiers. We offer tuition assistance and other incentives from seminars to discounts in health insurance costs for Wellness Programs.

7.3.E.2. Attachments for Section 7.3.E

7.3.E.2.1 *Organizational Chart*

An executive-level organizational chart is provided in *Figure 7.3-4* below.

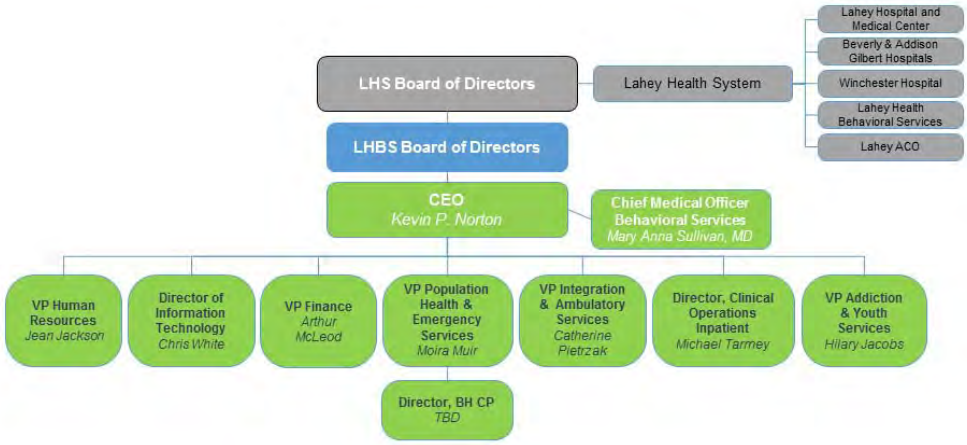


Figure 7.3-4: Organizational Chart

7.3.F. Implementation Plan and Timeline

LHBS has a long history of successfully implementing new programs. The implementation of the BH CP program will be led by the VP of Population Health and the Director of BH CP. LHBS's Director, Innovation and Strategic Planning has taken the lead for several strategic initiatives (CHART, Electronic Health Record Implementation, etc.) and is available to provide tools, guidance and support, as needed during program implementation.

The BH CP program implementation will be under the oversight of a cross-functional BH CP Implementation Oversight Committee (BHCP IOC). Members of the BHCP IOC include at a minimum, the LHBS CEO, CMO, CFO, CNO and Chief Quality Officer, as well as the Director of IT. The committee will be let by the VP of Population Health and supported by the Director of BH CP. The role of the Committee is to ensure that implementation activities are progressing according to schedule and to resolve issues and eliminate barriers to success.

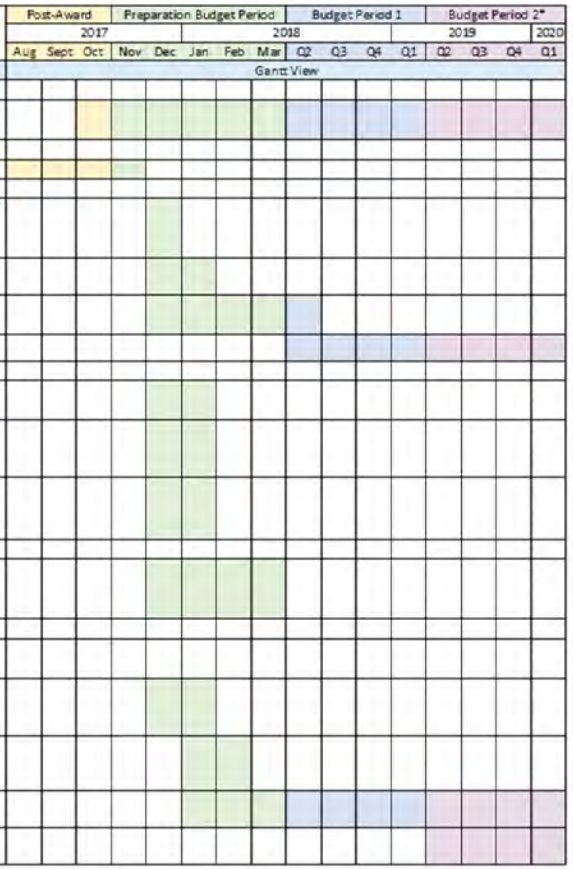
The five major components of work required to operationalize the BH CP program include Onboarding, Training, Program Readiness, Program Governance, and Operational Readiness activities. The Implementation Plan provided on the following pages is structured to reflect these categories of work and uses a Gantt view to display activities by month for the preparation budget period and by quarter for subsequent budget periods. This plan will be expanded to include additional details in late summer/early fall as implementation activities begin in earnest.

Several assumptions have been made in creating the Implementation Plan:

- ACO contracts executed 8/1
- CP awards made in August
- CP Contract start date 1/6~~1~~/17
- Program start date (new members enrolled) is ~~April~~ June 1, 2018
- Internal readiness activities will begin in August
- BH CP Director will be on board by 1~~1~~/1/18~~7~~

Leahy Health Behavioral Health Community Partners Implementation Plan *the plan and timeline will be revised to be in line with the new 8.1.18 start date and start of budget period 1.

WBS #	Deliverable/ Activity	Responsible	Start	End
0.0	**Project initation**			
0.1	**Convene LHBS BH CP Implementation Oversight Committee**	VP Pop Health (VP)	10/1/17	Ongoing
1.0	**Recruiting and Onboarding**			
1.1	**Hire Director of BH CP**	VP	8/1/17	12/1/17
1.2	**Recruitment**			
1.2.1	Develop strategy for recruiting clinical and non-clinical BH CP staff from local communities	HR, VP, BH CP Director (Director)	12/1/2017	12/31/2017
1.2.2	Develop detailed recruitment plan and process for reporting progress Director of BH CP (Director)	HR, Director	12/15/2017	1/15/2018
1.2.3	Execute recruitment plan to meet ramp up targets (dependent on 6.1)	HR, Director	12/15/2017	5/31/2018
1.2.4	Ongoing recruitment	HR, Director	4/1/2018	Ongoing
1.3	**Onboard Director of BH CP**			
1.3.1	Establish internal lines of communication between Director of BH CP and program leads across LHBS	VP, Director	12/1/2017	1/15/2018
1.3.2	Establish external lines of communication between Director of BH CP, VP of Population Health and external partners at EOHHS, ACOs and MCOs	VP, Director	12/1/2017	1/15/2018
1.3.3	Define role for Human Resources, Data Analytics, Billing, Finance, Compliance and Legal in support of BH CP program	Director	12/1/2017	1/15/2018
1.4	**Onboarding of all new staff to BH CP program**			
1.4.1	Develop and implement onboarding process, including all HR processes, provisions of access to equipment and space, and orientation and training schedule	Director, Steering Committee	12/1/2017	3/31/2018
2.0	**Training**			
2.1	**Enhance our current training programs, orientation plans, and modules for Care Coordinators**			
	Create BH CP training audience matrix including Key Stakeholders, mode of training, content of training and time frame for training	Director	12/1/2017	1/31/2018
	For each stakeholder cohort develop specific training plan (including dates for training and methods of obtaining feedback on effectiveness of training) (Dependent on 3.2)	Director	1/1/2018	2/28/2018
	Develop and deliver training as defined by training plan	Director, CP Staff	1/1/2018	Ongoing
	Provide continual education and data on the role and value of BH CP to ACO leadership	Director		Ongoing



* NOTE: Budget Period 2 activities are repeated in subsequent budget periods.

Leahy Health Behavioral Health Community Partners Implementation Plan

					Post-Award			Preparation Budget Period					Budget Period 1				Budget Period 2*			
					2017					2018							2019			2020
					Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
WBS #	Deliverable/ Activity	Responsible	Start	End	Gantt View															
0.0	**Project Initation**																			
0.1	**Convene LHBS BH CP Implementation Oversight Committee**	VP Pop Health (VP)	10/1/17	Ongoing																
1.0	**Recruiting and Onboarding**																			
1.1	**Hire Director of BH CP**	VP	8/1/17	12/1/17																
1.2	**Recruitment**																			
1.2.1	Develop strategy for recruiting clinical and non-clinical BH CP staff from local communities	HR, VP, BH CP Director (Director)	12/1/2017	12/31/2017																
1.2.2	Develop detailed recruitment plan and process for reporting progress Director of BH CP (Director)	HR, Director	12/15/2017	1/15/2018																
1.2.3	Execute recruitment plan to meet ramp up targets (dependent on 0.1)	HR, Director	12/15/2017	5/31/2018																
1.2.	Ongoing recruitment	HR, Director	4/1/2018	Ongoing																
1.3	**Onboard Director of BH CP**																			
1.3.1	Establish internal lines of communication between Director of BH CP and program leads across LHBS	VP, Director	12/1/2017	1/15/2018																
1.3.2	Establish external lines of communication between Director of BH CP, VP of Population Health and external partners at LCHHS, ACOs and MCOs	VP, Director	12/1/2017	1/15/2018																
1.3.3	Define role for Human Resources, Data Analytics, Billing, Finance, Compliance and Legal in support of BH CP program	Director	12/1/2017	1/15/2018																
1.4	**Onboarding of all new staff to BH CP program**																			
1.4.1	Develop and implement onboarding process, including all HR processes, provisions of access to equipment and space, and orientation and training schedule	Director, Steering Committee	12/1/2017	3/31/2018																
2.0	**Training**																			
2.1	**Enhance our current training programs, orientation plans, and modules for Care Coordinators**																			
	Create BH CP training audience matrix including key stakeholders, mode of training, content of training and time frame for training	Director	12/1/2017	1/31/2018																
	For each stakeholder cohort develop specific training plan (including dates for training and methods of obtaining feedback on effectiveness of training) (Dependent on 3.2)	Director	1/1/2018	2/28/2018																
	Develop and deliver training as defined by training plan	Director, CP Staff	1/1/2018	Ongoing																
	Provide continual education and data on the role and value of BH CP to ACO leadership	Director		Ongoing																

* NOTE: Budget Period 2 activities are repeated in subsequent budget periods.

Leahy Health Behavioral Health Community Partners Implementation Plan *the plan and timeline will be revised to be in line with the new 6.1.18 start date and start of budget period 1.

					Post-Award			Preparation Budget Period		Budget Period 1					Budget Period 2*				
					2017					2018					2019				2020
					Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
WBS #	Deliverable / Activity	Responsible	Start	End	Gantt View															
3.0	**Program Development and Implementation**																			
3.1	Develop or revise/update existing job descriptions	VP	9/1/2017	10/15/2017																
3.2	Develop workflows as needed and integrate into training materials and ongoing desk reference guides	Director, CP Staf	11/15/2017	3/15/2018																
3.3	Develop protocols for outreach to assigned members including documentation of outreach attempts, in person and by phone																			
3.4	Develop programs for health and wellness education including plan for enrolling members	Director	2/1/2018	3/31/2018																
3.5	Develop protocols for Care transitions	Director	2/1/2018	3/31/2018																
3.6	Develop protocols for Medication Reconciliation	Director	2/1/2018	3/31/2018																
3.7	Identify requirements for IT systems changes to allow documentation to support program requirements	IT, Director	1/1/2018	2/15/2018																
3.8	Collaborate with ACOs on flexible services	Director	3/1/2018	Ongoing																
3.9	Scale-up innovative IT applications as they are proven effective in BH CP target populations	Director, IT	4/1/2018	Ongoing																
3.10	Develop effective geo-mapping resource finder tool for care managers	VP, Director, IT	2/1/2018	4/30/2018																
3.11	Partner with ILCs, RLCs and other community organizations to assist with engaging assigned members	Director	3/1/2017	Ongoing																
3.12	**Grow Community Connections:**																			
3.12.1	Develop an inventory of social services available in the community to meet real and anticipated needs	CP Staff	2/1/2018	Ongoing																
3.12.2	Expand current resource manual for BH CP care coordinators	CP Staff	2/1/2018	3/31/2018																
3.12.3	Track gaps in community resource manual and work to identify new partners as needed	Director	2/1/2018	3/31/2018																
3.12.4	Coordinate closely with RLCs and ILCs for service provision and quality monitoring	Director	4/1/2018	Ongoing																
3.13	**Comprehensive Assessment and other Screening Tools (Coordinate with 3.2):**																			
3.13.1	Refine comprehensive assessment tool and gain EOHHS approval	Director	11/15/2017	2/15/2018																
3.13.2	Develop process and staffing model for scheduling, completing and reviewing assessments, including submission to MassHealth if needed	Director	11/15/2017	3/15/2018																
3.13.3	Develop process for hand-off between assessment team and care planning team to ensure cohesion	Director	11/15/2017	3/15/2018																
3.13.4	Develop care plan template within the EHR	IT, Director	11/15/2017	2/15/2018																

* NOTE: Budget Period 1 activities are repeated in subsequent budget periods.

Leahy Health Behavioral Health Community Partners Implementation Plan

WBS #	Deliverable/ Activity	Responsible	Start	End
3.0	**Program Development and Implementation:**			
3.1	Develop or revise/ update existing job descriptions	VP	9/1/2017	10/15/2017
3.2	Develop workflows as needed and integrate into training materials and ongoing desk reference guides	Director, CP Sta	11/15/2017	3/15/2018
3.3	Develop protocols for outreach to assigned members including documentation of outreach attempts, in person and by phone			
3.4	Develop programs for health and wellness education including plan for enrolling members	Director	2/1/2018	3/31/2018
3.5	Develop protocols for Care transitions	Director	2/1/2018	3/31/2018
3.6	Develop protocols for Medication Reconciliation	Director	2/1/2018	3/31/2018
3.7	Identify requirements for IT systems changes to allow documentation to support program requirements	IT, Director	1/1/2018	2/15/2018
3.8	Collaborate with ACOs on flexible services	Director	3/1/2018	Ongoing
3.9	Scale-up innovative IT applications as they are proven effective in BH CP target populations	Director, IT	4/1/2018	Ongoing
3.10	Develop effective geo-mapping resource finder tool for care managers	VP, Director, IT	2/1/2018	4/30/2018
3.11	Partner with ILCs, RLCs and other community organizations to assist with engaging assigned members	Director	3/1/2017	Ongoing
3.12	**Grow Community Connections:**			
3.12.1	Develop an inventory of social services available in the community to meet real and anticipated needs	CP Staff	2/1/2018	Ongoing
3.12.2	Expand current resource manual for BH CP care coordinators	CP Staff	2/1/2018	3/31/2018
3.12.3	Track gaps in community resource manual and work to identify new partners as needed	Director	2/1/2018	3/31/2018
3.12.4	Coordinate closely with RLCs and ILCs for service provision and quality monitoring	Director	4/1/2018	Ongoing
3.13	**Comprehensive Assessment and other Screening Tools (Coordinate with 3.2):**			
3.13.1	Refine comprehensive assessment tool and gain EOHHS approval	Director	11/15/2017	2/15/2018
3.13.2	Develop process and staffing model for scheduling, completing and reviewing assessments, including submission to MassHealth if needed	Director	11/15/2017	3/15/2018
3.13.3	Develop process for hand-off between assessment team and care planning team to ensure cohesion	Director	11/15/2017	3/15/2018
3.13.4	Develop care plan template within the EHR	IT, Director	11/15/2017	2/15/2018

Post-Award | Preparation Budget Period | Budget Period 1 | Budget Period 2*

2017 | 2018 | 2019 | 2020

Aug Sept Oct | Nov Dec | Jan Feb Mar | Q2 Q3 Q4 Q1 | Q2 Q3 Q4 Q1 | Q2 Q3 Q4 Q1

Gantt View

* NOTE: Budget Period 2 activities are repeated in subsequent budget periods.

Lealy Health Behavioral Health Community Partners Implementation Plan *the plan and timeline will be revised to be in line with the new 9.1.18 start date and start of budget period 1.

					Post-Award			Preparation Budget Period		Budget Period 1					Budget Period 2*			
					2017					2018					2019			2020
WBS #	Deliverable/ Activity	Responsible	Start	End	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
					Gantt View															
3.13.5	Develop workflow for systematically sharing care plan with PCP for review prior to finalizing. Transmit with MassHiWay or other secure, electronic communication method	Director, IT	11/15/2017	3/15/2018																
3.13.6	Develop process to secure and document member approval of care/ treatment plan	Director	11/15/2017	2/15/2018																
3.13.7	Develop screening tool for social services	Director	11/15/2017	3/15/2018																
4.0	**Program Governance**																			
4.1	LHBS Board of Directors																			
4.1.1	Engage LHBS Board of Directors in the implementation of the BH CP program, providing financial and programmatic oversight	VP	8/1/17	11/15/17																
4.1.2	Invite the Chair of the BH CP Consumer Advisory Board to join the LHBS Board of Directors	VP	10/1/17	12/31/17																
4.2	Expand Quality and Safety Council to include oversight of BH CP quality and performance metrics. Director of BH CP to attend appropriate sessions	VP	11/1/17	Ongoing																
4.2.1	Develop routine monitoring of program quality and improvements, when needed	VP, Director	11/1/17	Ongoing																
4.3	Establish Consumer Advisory Board for BH CP																			
4.3.1	Create preliminary description of roles and responsibilities for this Board	VP	12/1/17	12/31/17																
4.3.2	Distribute role description broadly throughout LHBS services and communities	VP	12/1/17	12/31/17																
4.3.3	Establish a Founding Committee for Consumer Advisory Board	VP	12/1/17	12/31/17																
4.3.4	Recruit, interview and Appoint members of the BH CP Consumer Advisory Board	Founding Committee	2/1/18	3/1/18																
4.3.5	Draft charter for the Consumer Advisory Board, including rules and policies about term limits, voting rules, documentation of	Founding Committee	1/15/18	3/30/18																
4.3.6	Provide orientation to BH CP program for BH CP Consumer Advisory Board members	VP, Director	3/1/18	3/30/18																
4.3.7	BH CP Consumer Advisory Board in effect	VP, Director	3/31/18																	
4.3.8	LHBS leaders to attend quarterly BH CP Consumer Advisory Board meetings	VP, VP Quality		Ongoing																
4.3.9	BH CP staff document Advisory Board input, provide follow-up between meetings, and report back on the impact on BH CP policies and procedures and operations resulting from this input	Director		Ongoing																

* NOTE: Budget Period 2 activities are repeated in subsequent budget periods.

Leahy Health Behavioral Health Community Partners Implementation Plan					Post-Award			Preparation Budget Period		Budget Period 1				Budget Period 2*			
					2017					2018				2019			2020
					Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
WBS #	Deliverable/ Activity	Responsible	Start	End	Gantt View															
3.13.5	Develop workflow for systematically sharing care plan with PCP for review prior to finalizing. Transmit with MassHIWay or other secure, electronic communication method	Director, IT	11/15/2017	3/15/2018																
3.13.6	Develop process to secure and document member approval of care/ treatment plan	Director	11/15/2017	2/15/2018																
3.13.7	Develop screening tool for social services	Director	11/15/2017	3/15/2018																
4.0	Program Governance																			
4.1	LHBS Board of Directors																			
4.1.1	Engage LHBS Board of Directors in the implementation of the BH CP program, providing financial and programmatic oversight	VP	8/1/17	11/15/17																
4.1.2	Invite the Chair of the BH CP Consumer Advisory Board to join the LHBS Board of Directors	VP	10/1/17	12/31/17																
4.2	Expand Quality and Safety Council to include oversight of BH CP quality and performance metrics. Director of BH CP to attend appropriate sessions	VP	11/1/17	Ongoing																
4.2.1	Develop routine monitoring of program quality and improvements, when needed	VP, Director	11/1/17	Ongoing																
4.3	Establish Consumer Advisory Board for BH CP																			
4.3.1	Create preliminary description of roles and responsibilities for this Board	VP	12/1/17	12/31/17																
4.3.2	Distribute role description broadly throughout LHBS services and communities	VP	12/1/17	12/31/17																
4.3.3	Establish a Founding Committee for Consumer Advisory Board	VP	12/1/17	12/31/17																
4.3.4	Recruit, Interview and Appoint members of the BH CP Consumer Advisory Board	Founding Committee	2/1/18	3/1/18																
4.3.5	Draft charter for the Consumer Advisory Board, including rules and policies about term limits, voting rules, documentation of	Founding Committee	1/15/18	3/30/18																
4.3.6	Provide orientation to BH CP program for BH CP Consumer Advisory Board members	VP, Director	3/1/18	3/30/18																
4.3.7	BH CP Consumer Advisory Board in effect	VP, Director	3/31/18																	
4.3.8	LHBS leaders to attend quarterly BH CP Consumer Advisory Board meetings	VP, VP Quality		Ongoing																
4.3.9	BH CP staff document Advisory Board input, provide follow-up between meetings, and report back on the impact on BH CP policies and procedures and operations resulting from this input.	Director		Ongoing																

* NOTE: Budget Period 2 activities are repeated in subsequent budget periods.

Leahy Health Behavioral Health Community Partners Implementation Plan *the plan and timeline will be revised to be in line with the new 6.1.18 start date and start of budget period 1.

					Post-Award			Preparation Budget Period					Budget Period 1				Budget Period 2*			
					2017			2018									2019			2020
					Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
WBS #	Deliverable / Activity	Responsible	Start	End	Gantt View															
5.0	**Operational Readiness**																			
	Demonstrate readiness no later than 15 business days prior to the operational start date (certification of readiness in a form and format specified by EOHHS)	VP, Director		5/15/18									*							
5.1	**Policies and Procedures:**																			
5.1.1	Update P&Ps for appeals and grievances - provide to EOHHS prior to the operational start date	Director	11/15/2017	2/15/2018																
5.1.2	Inventory all P&Ps that require updates and make updates		11/15/2017	2/15/2018																
5.1.3	Build the process to notify EOHHS on a monthly basis availability to accept new Assigned Enrollees	Director	1/15/2018	3/15/2018																
5.1.4	Develop process to prepare for quarterly performance review meetings with EOHHS	Director	4/1/2018	6/30/2018																
5.1.5	Develop and implement ongoing process to maintain DSRIP plan	VP	4/1/2018	6/30/2018																
5.1.6	Enrollment in MMIS or other processes required to receive payment	IT, Director	1/1/2018	3/15/2018																
5.2	**Member Materials:**																			
5.2.1	Develop written materials in compliance with contract requirements for accessibility	Director, VP of Quality	12/15/2017	5/1/2018																
5.3	**Reporting:**																			
	- Member status	Director	4/1/2018	Ongoing																
	- Quality measures	Director	4/1/2018	Ongoing																
	- Budget reports (prior to the start of each budget period)	Director	4/1/2018	Ongoing																
	- Annual and semiannual progress reports	Director	4/1/2018	Ongoing																
	- Additional as required	Director	4/1/2018	Ongoing																
5.3.1	Develop and maintain information system for data required under contract																			
5.3.1a	Document requirements and complete impact analysis	Director, IT	11/15/2017	4/30/2018																
5.3.1b	Document technical requirements and development plan	Director, IT	11/15/2017	4/30/2018																
5.3.1c	Modify/structure data warehouse to receive all reports from EOHHS, MCOs and ACOs	Director, IT	1/2/2018	6/30/2018																
5.3.1d	Modify/structure data warehouse to report on all required quality metrics to EOHHS, MCOs and ACOs	Director, IT	1/2/2018	6/30/2018																
5.3.2	Add capacity as needed to support reporting on member engagement metrics	Director, IT	11/15/2017	4/30/2018																

* NOTE: Budget Period 2 activities are repeated in subsequent budget periods.

Leahy Health Behavioral Health Community Partners Implementation Plan

WBS #	Deliverable/ Activity	Responsible	Start	End	Post-Award			Preparation Budget Period		Budget Period 1				Budget Period 2*			
					2017					2018				2019			2020
					Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
					Gantt View															
5.0	**Operational Readiness**																			
	Demonstrate readiness no later than 15 business days prior to the operational start date (certification of readiness in a form and format specified by EOHHS)	VP, Director		5/15/18									*							
5.1	**Policies and Procedures:**																			
5.1.1	Update P&Ps for appeals and grievances - provide to EOHHS prior to the operational start date	Director	11/15/2017	2/15/2018																
5.1.2	Inventory all P&Ps that require updates and make updates		11/15/2017	2/15/2018																
5.1.3	Build the process to notify EOHHS on a monthly basis availability to accept new Assigned Enrollees	Director	1/15/2018	3/15/2018																
5.1.4	Develop process to prepare for quarterly performance review meetings with EOHHS	Director	4/1/2018	6/30/2018																
5.1.5	Develop and implement ongoing process to maintain DSRIP plan	VP	4/1/2018	6/30/2018																
5.1.6	Enrollment in MMIS or other processes required to receive payment	IT, Director	1/1/2018	3/15/2018																
5.2	**Member Materials:**																			
5.2.1	Develop written materials in compliance with contract requirements for accessibility	Director, VP of Quality	12/15/2017	5/1/2018																
5.3	**Reporting:**																			
	- Member status	Director	4/1/2018	Ongoing																
	- Quality measures	Director	4/1/2018	Ongoing																
	- Budget reports (prior to the start of each budget period)	Director	4/1/2018	Ongoing																
	- Annual and semiannual progress reports	Director	4/1/2018	Ongoing																
	- Additional as required	Director	4/1/2018	Ongoing																
5.3.1	Develop and maintain information system for data required under contract																			
5.3.1a	Document requirements and complete impact analysis	Director, IT	11/15/2017	4/30/2018																
5.3.1b	Document technical requirements and development plan	Director, IT	11/15/2017	4/30/2018																
5.3.1c	Modify/structure data warehouse to receive all reports from EOHHS, MCOs and ACOs	Director, IT	1/2/2018	6/30/2018																
5.3.1d	Modify/structure data warehouse to report on all required quality metrics to EOHHS, MCOs and ACOs	Director, IT	1/2/2018	6/30/2018																
5.3.2	Add capacity as needed to support reporting on member engagement metrics	Director, IT	11/15/2017	4/30/2018																

* NOTE: Budget Period 2 activities are repeated in subsequent budget periods.

Leahy Health Behavioral Health Community Partners Implementation Plan *the plan and timeline will be revised to be in line with the new 8.1.18 start date and start of budget period 1.					Post-Award			Preparation Budget Period					Budget Period 1				Budget Period 2*			
					2017						2018						2019			2020
					Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
WBS #	Deliverable / Activity	Responsible	Start	End	Gantt View															
5.3.3	Collaborate with ACOs and MCOs to monitor and report on utilization metrics	Director, VP	4/1/2018	Ongoing																
5.3.4	Collaborate with ACOs and MCOs to monitor and report on member satisfaction metrics	Director, VP	4/1/2018	Ongoing																
5.3.5	Develop Qualifying Activity reporting (includes Comp. Assessment and Person-Centered plan)	Director, IT	1/15/2018	5/1/2018																
5.3.6	Develop critical incident reporting process	Director, IT	1/15/2018	5/1/2018																
5.4	**Billing Data:**																			
	Work with AdvantEdge Healthcare Solutions to ensure billing data available as needed	IT	11/15/2017	4/30/2018																
5.5	**Care Management Platform:**																			
	Roll-out integrated care management software to all BH CP staff	IT	11/15/2017	4/30/2018																
	Initiate conversations with all ACO and MCO partners about methods for sharing clinical information, including Mass HiWay and other electronic methods	IT	11/15/2017	4/30/2018																
	Update systems to meet the requirement of the BH CP program	IT	11/15/2017	3/31/2018																
	Update interpretive services contract as needed	VP, CFO	1/15/2018	4/30/2018																
5.6	**Customer Service Platform:**																			
	Select and implement customer service software platform integrated into the selected care management system	Director, IT	12/15/2017	Q4 2018																
5.7	**ACO Communications:**																			
	Establish communication protocols with all partner ACOs, leveraging IT where possible. Includes plan for communication of the care plan, the assessment results, medication reconciliation findings and follow-up after discharge. (Coordinate with section 3.0)	VP, Director	1/1/2018	4/30/2018																
	Contract with ACOs in the northern region	VP, CFO, Director	1/1/2018	5/1/2018																
	Develop process for resolving conflicts with ACOs	VP, Director	1/1/2018	5/15/2018																
	Work with ACOs and MCOs to develop analytic framework to measure value of BH CP	VP, Director	1/1/2020	Ongoing																
5.8	**Supplier Diversity Plan**																			
5.8.1	Submit SDP Plan form #2 - Declaration of SDP Partners	Director	1/1/2018	2/1/2018																
5.8.2	Submit SDP Plan form #3 - SDP Spending Report	Director	11/15/2017	5/31/2018																

* NOTE: Budget Period 2 activities are repeated in subsequent budget periods.

Leahy Health Behavioral Health Community Partners Implementation Plan

					Post-Award			Preparation Budget Period					Budget Period 1				Budget Period 2*			
					2017			2018									2019			2020
					Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
WBS #	Deliverable/ Activity	Responsible	Start	End	Gantt View															
5.3.3	Collaborate with ACOs and MCOs to monitor and report on utilization metrics	Director, VP	4/1/2018	Ongoing																
5.3.4	Collaborate with ACOs and MCOs to monitor and report on member satisfaction metrics	Director, VP	4/1/2018	Ongoing																
5.3.5	Develop Qualifying Activity reporting (includes Comp. Assessment and Person-Centered plan)	Director, IT	1/15/2018	5/1/2018																
5.3.6	Develop critical incident reporting process	Director, IT	1/15/2018	5/1/2018																
5.4	**Billing Data:**																			
	Work with AdvantEdge Healthcare Solutions to ensure billing data available as needed	IT	11/15/2017	4/30/2018																
5.5	**Care Management Platform:**																			
	Roll-out integrated care management software to all BH CP staff	IT	11/15/2017	4/30/2018																
	Initiate conversations with all ACO and MCO partners about methods for sharing clinical information, including Mass HIWay and other electronic methods	IT	11/15/2017	4/30/2018																
	Update systems to meet the requirement of the BH CP program	IT	11/15/2017	3/31/2018																
	Update interpretive services contract as needed	VP, CFO	1/15/2018	4/30/2018																
5.6	**Customer Service Platform:**																			
	Select and implement customer service software platform integrated into the selected care management system	Director, IT	12/15/2017	Q4 2018																
5.7	**ACO Communications**																			
	Establish communication protocols with all partner ACOs, leveraging IT where possible. Includes plan for communication of the care plan, the assessment results, medication reconciliation findings and follow up after discharge. (Coordinate with section 3.0)	VP, Director	1/1/2018	4/30/2018																
	Contract with ACOs in the northern region	VP, CFO, Director	1/1/2018	5/1/2018																
	Develop process for resolving conflicts with ACOs	VP, Director	1/1/2018	5/15/2018																
	Work with ACOs and MCOs to develop analytic framework to measure value of BH CP	VP, Director	1/1/2020	Ongoing																
5.8	**Supplier Diversity Plan**																			
5.8.	Submit SDP Plan form #2 - Declaration of SDP Partners	Director	1/1/2018	2/1/2018																
5.8.	Submit SDP Plan form #3 - SDP Spending Report	Director	11/15/2017	5/31/2018																

* NOTE: Budget period 2 activities are repeated in subsequent budget periods.

7.3.G. Sustainability

LHBS understands and appreciates the level of investment that MassHealth is making into building a strong care delivery system for MassHealth members. We believe that we can play a critical role in the transformation of the care delivery system in the northeast region of the Commonwealth, and more broadly through the development and sharing of best practices. We also believe that we have a responsibility to the Commonwealth to do our best to make this program succeed both in terms of improving quality and decreasing cost.

Our 10-Point Plan to Ensure Sustainability:

1. **Invest in the Future.** Over the next five years, LHBS will use DSRIP funds to develop the infrastructure and invest in the capacity to provide CP supports over the Contract Term and after the initial Contract Term. We will use these funds to develop the tools, resources and processes that are needed to bring effective supports to person with high BH needs, and to bring what is currently lacking in our care delivery system.
2. **Invest in Capacity and Infrastructure.** Broadly speaking, DSRIP funds should be used to invest in building capacity and infrastructure that we cannot build today because they are not funded under the fee-for-service system. Over the course of the next five years, we will invest in hiring and training a staff and paying for a care management software.
3. **Build Partnerships with Social Service and Community Organizations.** Over the course of the next five years, we will enter into a variety of relationships with social service agencies and community organizations to expand our ability to address the social determinants of health of our members.
4. **Deploy Best Practices.** There is a great deal that we know about the needs of individuals with high BH needs. We have developed many best practices in care coordination, which we have put to work in the ICC, CSP, HFY and CHART programs. This new BH CP program provides LHBS with an opportunity to advance what we know and to support ACOs and MCOs in providing better care with better outcomes for members at lower cost to individuals with high BH needs.
5. **Develop a Reputation for Quality and Responsiveness.** Part of what leads to success is simply being an excellent business partner. We can do that by establishing a reputation in the BH community and in the ACO and MCO communities for being fair, timely, responsive and manifesting the other essential attributes of what make a good business partner.
6. **Establish Strong Relationships with ACOs and MCOs.** Building strong relationships is key to our future. We plan to work closely with our ACOs and MCOs from day one. LHBS' VP of Population Health and the newly-hired BH CP Director will work with the ACOs and MCOs to establish a framework for measuring and evaluating the implications of CP supports on ACO total costs of care and MCO capitation rates.
7. **Create the Evidence Base.** We believe that we will generate a quantifiable return-on-investment to ACOs and MCOs from our delivery of CP supports to individuals with high BH needs. We see the next five years as the time during which we must make our business case to ACOs and MCOs that our services provide great value to outcomes of cost and quality. We will develop the evidence base needed to demonstrate to both ACOs and MCOs that our services directly contribute to positive outcomes for shared members..
8. **Move to Alternative Payment Methods (APMs).** Over the course of the next five years, we intend to establish APMs and new pricing methodologies that reflect our value add to

ACOs and MCOs to capture a share of the health care cost savings that ACOs and MCOs will capture under prospective payment systems. We intend to pilot and test these APMs in the early years to prepare for the final year of DSRIP when we will no longer receive funds via MassHealth but will need ACOs and MCOs to provide the funding for our services.

9. **Diversify Business.** We also see opportunities to develop business relationships with commercial payers, whose members with high BH needs may also benefit from CP Supports. Over the next five years, we will develop a portfolio of CP Supports that we can specifically market to commercial payers.
10. **Continue to Change and Improve.** At LHBS, we are committed to change and improvement beyond the five years of the initial Contract Term.

7.3.H. Quality Management and Performance Monitoring

As a CP, LHBS will meet all contract requirements related to quality management and performance monitoring by establishing and maintaining an EOHHS-approved quality improvement plan. The plan will include: (1) a systematic approach to improving processes and outcomes through the application of continuous quality improvement principles; (2) at least one specific quality improvement initiative that addresses–at a minimum–at least one of the following areas: quality of life; chronic disease management; caregiver stress; community tenure, isolation and social connectedness; care coordination and care management; or care transitions; and, an annual submission of its Quality Improvement Plan to EOHHS annually.

Approach to Improving Processes and Outcomes

LHBS prides itself on a culture of quality that is uniquely its own, where quality is the focus of the organization and its workforce every day. Quality is not an "add on" to the job, but it is woven into the fabric of the whole organization. LHBS is committed to innovation and to continuous quality improvement at all levels of the organization and in all programs. Within LHBS, we often turn to our clients and their families as one of the most important metrics of quality. The testimonials that we have included in the highlight below represent an honest reflection of what we are trying to achieve every day.

Highlight on What Our Clients Say About Our Quality*: LHBS offers a summary of what our clients say about us. We are committed to improving lives, and using resources most effectively.*

"This is the best help my daughter and I have ever received for learning how to talk with each other, and IHT helps guide what we expect of each other so that our expectations are realistic."

"The tools they have taught both myself and my son to learn how to better our relationship have been great."

"Ability to get treatment promptly. Therapist allowing me to be included in my treatment plan"

"The medication clinic is always helpful for me. Having therapy in the same place is very convenient… Flexibility in scheduling to meet our needs."

LHBS has a well-established quality management program today that we will leverage for the CP. This is articulated in LHBS Quality and Patient Safety Plan which describes the framework by which Lahey Health Behavioral Services (LHBS) continuously safeguards care and drives continuous performance improvement based on principles of best practice. The goal of this plan is to provide the highest value to patients by improving quality of care and the patient experience in the most effective and efficient way

The LHBS Quality and Safety Plan is designed to engage the entire workforce, ensure continued engagement and partnership with patients and their families, develop organizational improvement capabilities and provide support to make improvements within divisions of the

organization. Because LHBS is programmatically diverse and geographically dispersed, there is an effort to balance local quality efforts with strategic initiatives. Likewise, the LHBS' Quality Improvement Plan is based upon an organized framework for ongoing and systematic measurement, assessment and performance improvement activities. Components of this plan include a quick fix process for problems that do not need a comprehensive approach to problem solving and solution implementation, and quality assessment activities, such as patient satisfaction surveys, chart audits, medication therapy reviews. These activities help assure that standards are met and maintained and identify areas for review by quality improvement teams.

Current implementation of the Quality Improvement Plans are done through Quality Improvement Teams, which may be inter or intradepartmental. These committees, look at key issues to identify opportunities to improve process and outcomes using internal or external benchmark data to compare outcomes and focus improvement efforts. The committees use both LEAN process improvement methodologies and Plan-Do-Study-Act tests of change to find solutions that address the issue and the larger context of LHBS programs.

BH CP Quality Initiative: Improve Enrollee Engagement

LHBS will leverage the Quality Improvement Committee infrastructure, as well as a dedicated CP Quality Committee, to track progress on quality and process measures and goals, initiating improvement processes as needed. In the first year of the program, LHBS anticipates a focus on the implementation of a quality initiative around enrollee engagement (*Table 7.3-16*). Engagement is critical to improving the health and well-being of CP enrollees. It is challenging which is why we have proposed this for Year 1.

Table 7.3-16: LHBS' Quality Initiative for Budget Period 1
Promote Engagement Rates

Description	• LHBS proposes to implement in Budget Period 1 a quality initiative to promote engagement rates. Engagement is foundational to our ability to improve the quality of life and achieve the quality goals under DSRIP. • We know from our experience in our other care coordination/care management work of HFY and CHART that engagement rates in a medically and behaviorally complex population are a challenge. Specifically, our engagement rate for members served by our HFY CCs is 42 percent. It is markedly lower, at 25%, for our CHART members who are high ED utilizers.
Domains	• Engagement is a key component to a member's successful care coordination. • Engagement impacts all seven quality domains; prevention and wellness, chronic disease management, BH/SUD, member experience, integration, avoidable utilization and engagement. • We believe this quality initiative addresses the categories of Community Tenure, Isolation and Social Connectedness, Quality of Life, as well as Chronic Disease Management. Our strategy to tackle these categories is to leverage the lived experience of our members and draw upon best engagement practices.
Goals	• Our goal for the end of Year 1 is to achieve an engagement rate of 55 percent. • Design an engagement strategy that will help to build our business and engage members to operate at full capacity in the 9 service areas.

Table 7.3-16: LHBS' Quality Initiative for Budget Period 1 Promote Engagement Rates	
Definitions	• Engagement, as defined under the contract, is: "an Assigned Enrollee for whom (1) the Contractor has completed a Comprehensive Assessment and Person-Centered Treatment Plan, (2) the Person-Centered Treatment Plan has been approved by the Assigned Enrollee's PCP or PCP Designee and the Assigned Enrollee (or the Assigned Enrollee's legally authorized representative, as appropriate), and (3) the Contractor has submitted a "Person-Centered Treatment Plan complete" Qualifying Activity, as described in Section 2.5.C."
Design	• LHBS will create a quality initiative around the value of improving the rate of engagement among individuals with lived experience of SMI and SUD. • Engagement is critical to improving health outcomes. Many people who seek mental health care drop out after the first or second visit. (Source: NAMI, 2016.)
Strategies/ Methods	• Hire a dedicated engagement specialist who will be tasked primarily with outreach and engaging members to our BH CP. • Hire and train Care Coordinators who are culturally and linguistically appropriate for the members in the service areas. • Create materials that are linguistically and culturally appropriate. • Utilize the appropriate tool and best practices, including a strengths-based process. The Care Coordinators will outreach to the community through use of appropriate tools, including phone, email and text. • Train staff in tools and best practices. • Leverage the expertise of persons with lived experience of SMI and/or SUD.
Outcome Measures	• Our success in reaching our goal of achieving an engagement rate of 55 percent will be demonstrated by the recruitment and retention of qualified personnel, having optimal person to care coordinator ratios, and building relationships with ACO's to enlarge our referral base.

Quality Committee

LHBS has a Quality Safety Council that meets on a quarterly basis. This council is chaired by the Board of Trustees, and consists of the Chief Medical Officer (CMO), the Vice President of Quality, Safety, Compliance, and the Chief Nursing Office (CNO). The council also includes VPs, as well as LHBS Board of Trustee membership and other key system leaders.

The Council holds primary responsibility for the functioning of LHBS's quality assessment and performance improvement program; has primary responsibility for monitoring the Quality and Safety Program to assure that there is measurable improvement with indicators related to Health Outcomes, Error Reduction, Quality, Patient Safety and Performance Improvement; and, provides a quarterly Quality and Safety Summary Report to LHBS Board of Trustees.

LHBS also has a Quality and Safety Advisory Committee which advises the Quality and Safety Council of the current status of quality and safety within LHBS and makes recommendations for continuous improvement in quality, safety and client satisfaction as well identifies priorities in these areas. Participants on this committee include representatives from the Divisions and Programs throughout LHBS. This committee meets monthly and reports regularly to the Quality and Safety Council on Quality/Safety indicators in dashboard format, including roll-up measures of clinical quality, patient safety and customer service, progress on major performance

improvements and patient safety goals, Root Cause Analyses, Sentinel event summary and Accreditation status.

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7.3.I. Coordination with ACOs and MCOs

LHBS has prepared a plan for contracting with the ACOs and MCOs that reflects our vision for the future, and responds to the questions in this RFR.

Our Vision

It is our goal to establish a glide path that lays the foundation for the eventual exchange of care coordination payments from ACOs and MCOs to LHBS CP. At the end of five years, CPs and ACOs must be ready with a new strategy for paying for care coordination.

LHBS will contract with all ACOs and MCOs in the northeast region to provide CP supports to ACO enrollees in the Northeast region with high BH needs to improve the well-being of persons with lived experience of SMI and/or SUD, and to make an essential contribution to ACO and MCO performance under DSRIP and beyond. We will work to develop strong relationships with our ACO and MCO partners to achieve the goals under DSRIP and the long-term sustainability of our program. We will delineate our relative roles and responsibilities, performance standards for all parties, and data sharing obligations to each other to measure outcomes that are relevant to demonstrating our value.

We will leverage our rich history of working collaboratively with the MCOs and hospitals operating in MassHealth's northern region. As an ESP for 20 plus years, we have provided emergency services to 10 EDs in the northeast. (See *Table 7.3.-17*. below for a summary of the ACO bidders, as represented by the hospital names, with whom our ESPs work today.) Over the last three years, we have also collaborated closely with Lowell General under the CHART Grant Program to reduce 30-day ED "re-visits" by providing care coordination.

Table 7.3-17: Lahey's Existing Relationships with Potential ACOs and MCOs

MassHealth ACO Bidders	Participating MassHealth MCOs
• Anna Jaques Hospital • Addison Gilbert Hospital • Beverly Hospital • Lahey Hospital and Medical Center • Winchester Hospital • Lawrence General Hospital • North Shore Medical Center • Holy Family Hospital (Haverhill) • Holy Family Hospital (Methuen) • Lowell General Hospital (Main Campus) • Lowell General Hospital (Saints Campus)	• All plans operating in the northeast region: • Boston Medical Center HealthNet • Neighborhood Health Plan • Tufts Health Plan • Fallon Community Health Plan

Communication to ACOs and MCOs

We will communicate our skills, expertise and value to potential ACO and MCOs. The LHBS Leadership Team, Program Directors, and marketing and communication experts will work collaboratively to increase and sustain awareness of our capacity to provide high-quality BH and care management services to ACOs and MCOs within the relevant service areas. In collaboration with each local Program Director, we will create an annual plan to keep ACOs and MCOs informed of our capacity, expertise and the role BH plays in that community's overall population health. We will support, provide opportunities and coach local Program Directors. We will provide expert speakers and panelists to community and regionally-based educational events or conferences on relevant topics, such as integrated care, addiction, public health awareness, mental health treatment access and overdose prevention. We will provide no-cost trainings such as presentations on pain management and addiction, overdose prevention, medication-assisted treatments, and integrated care and cost savings.

Branding and Marketing

Branding: LHBS is a forward-thinking innovator in integrated care, at the forefront of providing a continuum of services that are seamlessly delivered by a community-based network of health providers which are responsive to current and emerging local needs. LHBS will emphasize four unique synergies of strength: clinical expertise; cost-efficient quality; superior patient experience; and "force for good" within the communities that we serve.

Marketing: LHBS will rely upon a combination of marketing approaches–some old, some new–to market this program. Key strategies include: in person, media, digital, paid for advertising campaign, and printed collateral.

Engagement and Strategy with Multiple ACOs and MCOs in the Service Areas

We will engage and collaborate with multiple ACOs and MCOs. As a BH CP, LHBS intends to convey to ACOs and MCOs our 50+ years of experience and skill serving the MassHealth population, our robust continuum of behavioral health services, and our experience in providing care coordination and care management to MassHealth members through our ICC and Here For You program with NHP that lead to better outcomes. We will hold in-person meetings with ACO leaders to support the goals of the ACO and BH CP.

Strategy for Conflict Resolution

LHBS will establish a process for resolving conflicts that is based on a model of streamlined governance. The Director of the BH CP will attempt to resolve any conflicts with ACOs and MCOs. However, if the matter cannot be resolved at that level, then the VP of Population Health and Emergency Services will address the conflict. LHBS strongly believes that all conflicts can and should be resolved.

Community Partner Program Budget Report

Greater Lowell BH Community Partner/ Lowell Community Health Center

Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Estimated Enrollees- Start of Period (All Enrollees)		0	750	1,150	1,400	1,750	
Estimated Enrollees - End of Period (All Enrollees)		750	1,150	1,400	1,750	1,750	
Estimated Enrollees - Monthly Average (excl CBFS enrollees)		700	1,100	1,200	1,550	1,550	
Estimated Enrollees - Monthly Average (CBFS enrollees only)		50	50	200	200	200	
Estimated Program Revenue (excl CBFS enrollees)		$ 882,000	$ 2,376,000	$ 2,592,000	$ 3,348,000	$ 3,348,000	$ 12,546,000
Estimated Program Revenue (CBFS enrollees only)		$ 87,500	$ 150,000	$ 600,000	$ 600,000	$ 600,000	$ 2,037,500
Total Estimated Program Revenue		**$ 969,500**	**$ 2,526,000**	**$ 3,192,000**	**$ 3,948,000**	**$ 3,948,000**	**$ 14,583,500**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -	$ -	$ -	$ -
Revenue for Operations		**$ 969,500**	**$ 2,526,000**	**$ 3,192,000**	**$ 3,948,000**	**$ 3,948,000**	**$ 14,583,500**

	Program Expenses		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
1	**Salary**		$ 144,045	$ 613,684	$ 1,642,363	$ 1,947,758	$ 2,424,642	$ 2,441,902	$ 9,214,394
2	**Fringe**		$ 27,801	$ 110,470	$ 316,821	$ 377,654	$ 467,956	$ 470,884	$ 1,771,586
	Total Personnel Costs		$ 171,846	$ 724,154	$ 1,959,184	$ 2,325,412	$ 2,892,598	$ 2,912,786	$ 10,985,980
3	**Training & Professional Development**		$ 3,200	$ 9,200	$ 15,000	$ 15,000	$ 15,000	$ 15,000	$ 72,400
4	**Travel**		$ 853	$ 7,758	$ 19,440	$ 24,192	$ 28,512	$ 28,512	$ 109,267
5	**Equipment**		$ 900	$ 2,100	$ 3,600	$ 3,600	$ 3,600	$ 3,600	$ 17,400
6	**Supplies**		$ 1,960	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 26,960
7	**Contract Services** (consulting, professional)		$17,228	$140,000	$220,000	$220,000	$220,000	$200,000	$ 1,017,228
8	**Software licensing**			$ 16,100	$ 27,600	$ 27,600	$ 27,600	$ 27,600	$ 126,500
9	**Telecommunications**		$ 2,213	$ 31,524	$ 31,524	$ 31,524	$ 31,524	$ 31,524	$ 159,833
10	**Occupancy** (rent, utilities, maintenance)		$7,624	$25,667	$66,700	$77,140	$82,360	$82,360	$ 341,851
11	**Other**		$ 13,600	$ 11,200	$ 11,200	$ 11,200	$ 11,200	$ 11,200	$ 69,600
	Total Direct Costs		$ 219,424	$ 972,703	$ 2,359,248	$ 2,740,668	$ 3,317,394	$ 3,317,582	$ 12,927,019
12	**Indirect Cost/Administrative Overhead**	**19.0%**	**$ 41,691**	**$ 184,814**	**$ 448,257**	**$ 520,727**	**$ 630,305**	**$ 630,341**	$ 2,456,134
	TOTAL EXPENSES		$ 261,115	$ 1,157,517	$ 2,807,505	$ 3,261,395	$ 3,947,699	$ 3,947,923	$ 15,383,153
	Surplus/Shortfall		*$ (261,115)*	*$ (188,017)*	*$ (281,505)*	*$ (69,395)*	*$ 301*	*$ 77*	*$ (799,653)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Program Director/ Director of Case Manag	$120,000	1	6	$ 60,000
Lead RN	$70,000	1	3	$ 17,500
Medical Director	$ 150,000.00	0.25	1	$ 3,125
Case Managers(Care Coordinators), BA Level, Team 1	$42,000	1	2	$ 7,000
Case Managers(Care Coordinators), BA Level, Team 2	$42,000	1	1	$ 3,500
Case Manager, LCSW, Team 3	$50,000	1	2	$ 8,334
RN	$65,000	1	1	$ 5,416
Community Health Worker, Teams 1 and 4	$35,000	2	2	$ 11,668
Community Health Worker, Team 2	$35,000	1	1	$ 2,917
Peer Specialist/ Recovery Coach	$30,000	2	1	$ 5,000
Admin Asst	$35,000	1	5	$ 14,585
Intake Coordinator	$30,000	2	1	$ 5,000
Total Salary (Program Budget Line 1)		**14.25**		**$ 144,045.00**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 144,045.00	19.3%	$ 27,801
Total Fringe (Program Budget Line 2)			**$ 27,801**

Total Personnel*	**$ 171,846**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

Program Director (1.0FTE) Overall supervision and accountability for the program development and implementation. Program Director also serves as Director of Case Management. BH CP Program Director will be the main point of contact for leadership from the three affiliated organizations as well as the ACO/MCO partners and community based organizations.

Lead RN (1.0 FTE): Program development on ongoing clinical oversight for the case managers. Lead RN will lead team to review the assessments and complete medication reconciliation. Clinical back-up for Case Managers and Community Health Workers

Medical Director (0.25 FTE): Medical Director will provide clinical oversight of the program and provide consultations to case managers and RNs

Case Managers (Care Coordinators) -- 2 BA level, one LCSW (3.0 FTE): Primary contact with members for care coordination

RN (1.0 FTE)- Support all teams of case managers with assessments, medication reconciliation and clinical care

Community Health Worker (3.0 FTE): Collaborate with Case Managers to provide face-to-face contact for members, coordinate services including LTSS and Flexible Support

Peer Specialist (1.0 FTE): Provide extra support to members with SMI, resource to the Case Managers

Recovery Coach (1.0 FTE): Provide extra support to members in recovery from SUD, resource to the Case Managers

Admin Assistant (1.0 FTE): Provide administrative support to entire program

Admin Assistant (1.0 FTE): Provide administrative support to entire program.

Intake Coordinator (1.0 FTE): Outreach to new members to engage in the program, schedule comprehensive assessments

Staffing pattern for the PBP listed above does not align with the staffing model for BP 1 (tab 7) due to

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Professional Development funding	$400	8	$3,200
Total Training and Professional Development (Program Budget Line 3)			**$ 3,200.00**

Provide a description of each Training and Professional Development line item included in the table above:

$400 per clinical staff member (8 FTE) to support training programs on clinical case management, CEUs or licensing fees

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
Program Director	100	6	0.535	$ 321.00
Lead RN	100	3	0.535	$ 160.50
Case Managers	100	3	0.535	$ 160.50
Community Health Workers	100	3	0.535	$ 160.50
				$ 803.00

Travel Expense Description	Cost
Total Mileage	$ 803.00
Parking and tolls	$ 50.00
Public transportation	
Enrollee travel	

	A	B
89	**Total Travel**	
90	**(Program Budget Line 4)**	**$ 853.00**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

Reimbursement for travel calculates at IRS approved rate of $.535

We estimate that the Program Director will travel approximately 100 miles per month to meetings and other engagements to establish the program.

The Lead RN will also travel approximately 100 miles per month after they start.

The Case Managers and Community Health Workers will travel an estimated 100 miles per month each for the last month of the pre-budget period to establish relationships with community based organizations.

Parking in the Lowell service area is typically low cost or free. Minimal parking included in budget to cover costs for travel outside of our service area.

Row 5 - Equipment

Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost
Rent photo copy machine	300/ month	3 months	$ 900.00
Total Equipment (Program Budget Line 5)			**$ 900.00**

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

The program will rent one photo copy machine to support all program functions. The cost is $300 per month including toner.

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
General office supplies	140	14	$1,960
Total Supplies (Program Budget Line 6)			**$1,960**

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Office Supplies to establish workstations for staff during the preparation period. Includes paper, notebooks, pens and other basic supplies for each of three staff locations.

Estimates from the costs of similar sized programs.

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Health Management Associates	Consultant	Consulting	$ 15,000.00
Verill Dana	Legal	Legal	$2,228.00
Total Contract Services (Program Budget Line 7)			**$ 17,228.00**

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Health Management Associates will provide support as Acting Program Director until the Program Director is hired to initiate program development and consultation on strategic decisions. Resources not used for preparation for contracting.

- Task 1: Strategic consulatation to clarify the model of care and infrastructure resources across three affiliated partners. 20 hours. Rate: $270 per hour.

***- Task 2: Establish cross-agency workplan to ensure program is set up to achieve the goals and deliverables as outlined u the proposal to the Commonwealth*. 30 hours. Rate: $270/ hour.**

- Task 3: Provide strategic guidance and support, as needed, to address issues. 4 hours. $275/hour

- Task 3: Provide strategic guidance and support, as needed, to address issues. 4 hours. $375/hour

Verill Dana Lawfirm will provide legal assistance to outline terms of the affiliation agreement between partners. Legal counsel not used for contracting with EOHHS.

- 5.50 hours. Rate: $405/hour

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
		Total Software Licensing (Program Budget Line 8)	

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

There is no software licensing fees in this pre-budget period.

The program will pay $2,300 per month to license software for IT platform starting in year 1.

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Cell Phone with Data	$64/ month	22	$ 1,408.00
MiFi Hot Spots	$35/ month	13	$ 455.00

	A	B	C	D	E	F
230	Tablet Data Plan via Verizon	$35/ month	10	$ 350.00		
231						
232						
233			**Total Telecommunications**	**$ 2,213.00**		
234			**(Program Budget Line 9)**			

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

22 staff months (for cell phone eligible staff) x $64.00 per month for cell phone and plan. Will enable staff to communicate with members and other staff when in the field
13 staff months (for staff needing hot spots for job functions) x $35 per month for MiFi hotspot. Will enable home visits by granting access to the internet when out of the office.
10 staff months for clinical staff needing a tablet for home visits x $35 per month for data plan. Will allow efficient completion of assessments and care plans through mobile platform.

Row 10 - Occupancy

Occupancy Expense	**Total SqFt**	**Cost/SqFT**	**Cost**
Rent and Facilities Fee Dec - Feb	260	2.083/ mo	$ 1,625.00
Rent and Facilities Fee Mar - May	960	2.083/ mon	$ 5,999.00
			$ -
			$ -
			$ -
Total Occupancy (Program Budget Line 10)			**$ 7,624.00**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

Annual facility cost (rent) for lead agency is $25.00/ sq ft

Annual facility cost (rent) for lead agency is $25.00/ sq ft; .

The space demands will grow during the pre-bedget period as staff are hired.

December, January and February (3 months):
Program Director Office = 100 Square Feet
IT Program Manager and Admin Assistant cubicles = 160 square feet total
These staff will all be located in Lowell Community Health Center space.

March, April and May (3 months)
Program Director Office = 100 Square Feet
Lead RN Office = 100 Square Feet
IT Project Manager, Admin Asst, RN 2, Intake Coordinator 1, Intake Coordinator 2 = 80 square feet workstations = 400 Square Feet total
Care Coordination Teams = 6 staff – shared workspaces, floating: 60 Square Feet per person = 360 SQ
These staff will be hired by all affiliated partners (a combination), housed either in Lowell Community Health Center space or with other affiliated partners depeding on space availability.

Additional occupancy costs include $2.50/ square foot allocated costs for maintenance (based on the current experience of lead agency) and $1.50/ square foot allocated costs for housekeeping. These costs will not be attributed to the BH CP for the prep budget period.

Row 11 - Other

Other Direct Expense Description	Cost
Cost of initiating consumer advisory board, including food, materials and transportation	$800
Cost of initiating governanace committee meetings, including food and materials	$400
Contributions to program development and implementation from non-program clinical staff at LCHC, MHA and LHI	$12,400
Total Other (Program Budget Line 11)	**$ 13,600.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Contributions from existing staff: Existing staff at each of the three partner organizations will contribute to

program development, engagement of ACOs and community-based organizations, recruitment and strategic decision-making through the preparation period. Staff include clinical ledership from each organization.

Funds are allocated to 60% to Lowell CHC, 20% to MHA and 20% to Lowell House to cover this time.

Funds to launch the Consumer Advisory Committee will be used for meeting materials, food and transportation as needed for members to participate in meeting(s). 2 meetings in prep budget period.

Funds to launch the Governance Committee will be used for meeting materials and food. 2 meetings in prep budget period.

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	19.00%	$41,691

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Federally approved overhead rate for Lowell Community Health Center, Lead Agency, is 29%. We will use an overhead rate of 19% for this budget period.

	A	B	C	D	E	F
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Community Partner Infrastructure Budget Report

		Greater Lowell BH Community Partner/ Lowell Community Health Center						
	Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
	PMPM Infrastructure Rate		$ 100.00	$ 86.04	$ 51.49	$ 45.40	$ 39.28	
	Engaged Enrollees		750	750	1,150	1,400	1,750	
	Estimated Infrastructure Funds		$ 525,000	$ 774,360	$ 710,562	$ 762,720	$ 824,880	**$ 3,597,522**
	At- Risk Withhold Rate			25%	44%	63%	81%	
	Withhold			$ 193,590	$ 312,647	$ 480,514	$ 668,153	**$ 1,654,904**
	TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 525,000	$ 580,770	$ 397,915	$ 282,206	$ 156,727	**$ 2,392,618**

	Infrastructure Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
	Technology								
1	**IT Staffing including Fringe**		$ 41,755	$ 48,714	$ 85,810	$ 86,884	$ 88,616	$ 90,391	**$ 442,170**
2	**Development Adaptation of EHR and/or Care Management System**		$ 60,000	$ 40,000		$ -	$ -	$ -	**$ 100,000**
3	**Technology for Service Delivery**		$ 7,500	$ 6,000	$ 6,000	$ 6,000	$ 6,000	$ 6,000	**$ 37,500**
4	**Other Technology Expenses**		$ 3,000	$ 68,840	$ 20,000	$ 17,000	$ 17,000	$ 17,000	**$ 142,840**
	Total Technology		$ 112,255	$ 163,554	$ 111,810	$ 109,884	$ 111,616	$ 113,391	**$ 722,510**
	Workforce Development								
5	**Workforce Development staffing including Fringe**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
6	**Recruitment Expenses**		$ 7,165	$ 9,000	$ 6,000	$ 6,000	$ 6,000	$ 2,000	**$ 36,165**
7	**Training Expenses**		$ 6,850	$ 10,000	$ 12,800	$ 12,800	$ 12,800	$ 12,800	**$ 68,050**
8	**Retention Expenses**		$ -	$ -	$ 25,000	$ 50,000	$ 50,000		**$ 125,000**
	Total Workforce Development		$ 14,015	$ 19,000	$ 43,800	$ 68,800	$ 68,800	$ 14,800	**$ 229,215**
	Business Start Up Costs								
9	**Office Equipment (PBP & BP1 only)**		$ 14,560.00	$ 10,900.00					**$ 25,460**
10	**Office Furniture (PBP & BP1 only)**		$ 17,896.00	$ 40,008.00					**$ 57,904**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**		$ 261,115	$ 188,017	$ 281,505	$ 69,395			**$ 800,031**
	Total Business Start Up Costs		$ 293,571	$ 238,925	$ 281,505	$ 69,395			**$ 883,395**
	Operational Infrastructure								
12	**Operation Staffing including Fringe**		$ -	$ 48,711	$ 85,810	$ 86,884	$ 88,616	$ 90,391	**$ 400,412**
13	**Other Operational Expenses**			$ 1,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	**$ 41,000**
	Total Operational Infrastructure		$ -	$ 49,711	$ 95,810	$ 96,884	$ 98,616	$ 100,391	**$ 441,412**
14	**Indirect Cost/Administrative Overhead Rate**	19.0%	$ 30,158	$ 53,803	$ 47,770	$ 52,358	$ 53,016	$ 43,431	**$ 280,535**
	TOTAL INVESTMENTS		**$ 449,999**	**$ 524,992**	**$ 580,695**	**$ 397,321**	**$ 332,048**	**$ 272,013**	$ 2,557,067

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
IT Project Manager	$70,000	1	6	$ 35,000
	Total Salary			$ 35,000
	Fringe rate	19.3%	Total Fringe	$ 6,755
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 41,755**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

The IT project manager is a key part of the program development team during the preparation period. The Manager will be responsible for developing an RFP to select an IT vendor to provide a case management system, working with the program director and clinical teams at all affiliated organizations to define the specifications for the IT platform and for the implementation of the system. IT Manager will also participate in discussions with the ACOs about information sharing and interfaces.

All infrastructure expenses in the PBP allocated 60% to Lowell CHC (lead agency), 20% to Mental Health Association of Greater

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Initial Design and Implementation of IT Platform	$ 60,000.00

	A	B	C	D	E	F	G
34							
35							
36							
37							
38							
39	**Total Development and Adaptation of EHR and Care**						
40	**Management System**	$ 60,000.00					
41	**(Infrastructure Budget Line 2)**						
42							
43	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
44	***contract and how the costs were determined:***						
45							
46	***Estimate of the cost for the design and implementation of the IT case management platform based on quotes from potential***						
47	***vendors. Case management system required for documentation and reporting, and also to provide proactive case management***						
48	***services to all members across three affiliated partners.***						
49							
50	***Costs for the implementation of the system also allocated to Budget Year 1 ($40,000)***						
51							
52	***All infrastructure expenses in the PBP allocated 60% to Lowell CHC (lead agency), 20% to Mental Health Association of Greater***						
53	***Lowell and 20% to Lowell House Inc based on anticipated distribution of staff***						
54							
55							
56							
57							
58	**Row 3 - Technology for Service Delivery**						
59	**Description of Expense**	**Cost**					
60	Purchase of Tablets for Clinical Team	$7,500					
61							
62							
63							
64							
65							
66	**Total Technology for Service Delivery**	$ 7,500.00					

	A	B	C	D	E	F	G
67	**(Infrastructure Budget Line 3)**	**$ 7,500.00**					
68							
69	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
70	***contract and how the costs were determined:***						
71							
72	***The BH CP will purchase a tablet for each clinical staff person (10 FTEs in the prep budget period) to enable staff to efficiently***						
73	***complete the assessments and care planning processes while working with members outside of the office settings.***						
74							
75	***All infrastructure expenses in the PBP allocated 60% to Lowell CHC (lead agency), 20% to Mental Health Association of Greater***						
76	***Lowell and 20% to Lowell House Inc based on anticipated distribution of staff***						
77							
78							
79							
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81							
82							
83							
84							
85	**Row 4 - Other Technology Expenses**						
86	**Description of Expense**	**Cost**					
87	Investment in Data and Analytics Infrastructure	$ 3,000.00					
88							
89							
90							
91							
92							
93	**Total Other Technology Expenses**	**$ 3,000.00**					
94	**(Infrastructure Budget Line 4)**						
95							
96	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
97	***contract and how the costs were determined:***						
98							
99	Investments in building data and analytic capacity for routine reporting and monitoring of quality performance estimated to be						

$3,000 during the preparation period. These funds will be included in the scope of work for our IT software vendor to build reporting capability.

All infrastructure expenses in the PBP allocated 60% to Lowell CHC (lead agency), 20% to Mental Health Association of Greater Lowell and 20% to Lowell House Inc based on anticipated distribution of staff

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

No new workforce development staff are proposed for this program. Workforce development activities will be managed by Program Director in concert with existing resources at organizations.

Row 6 - Recruitment Expenses

Description of Expense	Cost
Cyber Recruiter to manage recruitment process	$ 935.00
Sponsored Jobs of Indeed -- online postings	$ 4,200.00
Mass Association of Social Workers	$ 1,600.00
Materials and Flyers	$ 435.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 7,165.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

External Recruitment for RN, Case Managers, Community Health Workers and Admin Assistant positions, including local marketing. Additional recruitment done through informal channels by all affiliated partners within the Lowell area.

Costs include:
Allocated cost for Cyber Recruiter -- vendor organization to support recruitment activities, tracking ($935 allocated based on volume of recruits)

Sponsored Jobs on Indeed. Sponsored Jobs are highlighted in search results and receive greater visibility than free job listings to increase return. $300/position/month. 6 positions for 2 months- $300 X 6 positions X 2 months = $4,200

Mass Association of Social Workers- approx. $400 for publishing a 1/8 page advertisement in Social Work Voice and 6-8 weeks on-line. $400 X 4 issues= $1,600

We will partner with local Community Health Worker training programs to advertise positions to graduates, using matierals and flyers.

Recruitment expenses in the PBP allocated 60% to Lowell CHC (lead agency), 20% to Mental Health Association of Greater Lowell

Row 7 - Training Expenses

Description of Expense	Cost
Developing training curriculum with local community based organizations	$ 2,500.00
Producing resources and training binder for staff	$ 500.00
Certification training for CHW and Case Managers (as needed)	$ 3,850.00
Total Training Expenses (Infrastructure Budget Line 7)	**$ 6,850.00**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Training expenses in the prep budget period include working closely with other community based providers to develop the curriculum for program staff to continually build skills in referrals, services available within the community, cultural competence and best practices. We estimate that developing the curriculum will cost $2,500 and supporting materials will cost $500.

$4400 has been allocated to support clinical staff to gain or maintain certification in case management or as a CHW, as needed. Cost estimated at $550 per FTE, with up to 7 staff eligible for the funding. Will be driven by need once staff are recruited.

All infrastructure expenses in the PBP allocated 60% to Lowell CHC lead agency), 20% to Mental Health Association of Greater Lowell and 20% to Lowell House Inc based on anticipated distribution of staff

Row 8 - Retention Expenses

Description of Expense	Cost
Total Retention Expenses (Infrastructure Budget Line 8)	

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Retention expenses are not anticipated in the preparation budget period.

Community Partner <u>Infrastructure</u> Budget Report - Business Start Up Costs - Prep Budget Period

Row 9 - Office Equipment

Description of Expense	Cost
Office equipment for 14 new staff including computers, phones, printers	$14,560
Total Office Equipment (Infrastructure Budget Line 9)	**$14,560**

Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were determined:

Cost of office equipment for new staff estimated at $1,040 per workspace based on previous experience and current rates. 14 staff will receive new office equipment in the prep budget period.

All infrastructure expenses in the PBP allocated 60% to Lowell CHC (lead agency), 20% to Mental Health Association of Greater Lowell and 20% to Lowell House Inc based on anticipated distribution of staff

Row 10 - Office Furniture

Description of Expense	Cost
Desks for 14 Staff people	$ 7,868.00
Chairs for 14 staff people	$ 2,828.00
Cubicles for 12 staff people	$ 7,200.00

	A	B
257		
258		
259		
260	**Total Office Furniture**	**$ 17,896.00**
261	**(Infrastructure Budget Line 10)**	

Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:

Costs estimated based on past supply purchases, standard pricing list.
Desks: $562 per desk
Office chairs: $202 per chair
Cubicles: $600 for 4 foot set-up

All infrastructure expenses in the PBP allocated 60% to Lowell CHC (lead agency), 20% to Mental Health Association of Greater Lowell and 20% to Lowell House Inc based on anticipated distribution of staff

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -

	A	B	C	D	E	F	G
289					$ -		
290					$ -		
291		Total Salary	0		$ -		
292		Fringe rate		Total Fringe	$ -		
293				**Total Program Staffing including Fringe**			
294				**(Infrastructure Budget Line 12)**	**$ -**		

295 ***For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:***

Project Management, data analytics and quality managment support needs are not anticipated during the preparation budget period.

306

307 **Row 13 - Other Operational Expenses**

308	Description of Expense	Cost
309		
310		
311		
312		
313		
314		
315	**Total Other Operational Expenses**	
316	**(Infrastructure Budget Line 13)**	

317

318 ***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms***
319 ***of the CP's contract and how the costs were determined:***

320

321 ***Project Management support is not anticipated during the preparation budget period.***

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**19.00%**	**$ 30,158.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Federally approved overhead rate for Lowell Community Health Center, Lead Agency, is 29%. We will use an overhead rate of 19% for this budget period.

	A	B	C	D	E	F	G
352							
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Community Partner Infrastructure Allocation Worksheet

	Greater Lowell Behavioral Health Community Partners/ Lowell Community Health Center						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 525,000	$ 580,770	$ 397,915	$ 282,206	$ 156,727	$ 2,392,618
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Lowell Community Health Center, Lead Agency	$ 67,353	$ 98,132	$ 67,086	$ 65,930	$ 66,970	$ 68,035	$ 433,506
Lowell House, Inc	$ 22,451	$ 32,711	$ 22,362	$ 21,977	$ 22,323	$ 22,678	$ 144,502
Mental Health Association of Greater Lowell	$ 22,451	$ 32,711	$ 22,362	$ 21,977	$ 22,323	$ 22,678	$ 144,502
Consortium Entity or Affiliated Partner							
Consortium Entity or Affiliated Partner							
Total Technology	$ 112,255	$ 163,554	$ 111,810	$ 109,884	$ 111,616	$ 113,391	$ 722,510
Workforce Development							
Lowell Community Health Center, Lead Agency	$ 8,409	$ 11,400	$ 26,280	$ 41,280	$ 41,280	$ 8,880	$ 137,529
Lowell House, Inc	$ 2,803	$ 3,800	$ 8,760	$ 13,760	$ 13,760	$ 2,960	$ 45,843
Mental Health Association of Greater Lowell	$ 2,803	$ 3,800	$ 8,760	$ 13,760	$ 13,760	$ 2,960	$ 45,843
Consortium Entity or Affiliated Partner							
Consortium Entity or Affiliated Partner							
Total Workforce Development	$ 14,015	$ 19,000	$ 43,800	$ 68,800	$ 68,800	$ 14,800	$ 229,215
Business Start Up Costs							
Lowell Community Health Center, Lead Agency	$ 176,155	$ 143,355	$ 168,903	$ 41,637			$ 530,050
Lowell House, Inc	$ 58,718	$ 47,785	$ 56,301	$ 13,879			$ 176,683
Mental Health Association of Greater Lowell	$ 58,718	$ 47,785	$ 56,301	$ 13,879			$ 176,683
Consortium Entity or Affiliated Partner							
Consortium Entity or Affiliated Partner							
Business Start Up Costs	$ 293,591	$ 238,925	$ 281,505	$ 69,395	$ -	$ -	$ 883,416
Operational Infrastructure							
Lowell Community Health Center, Lead Agency		$29,827	$ 57,486	$ 58,130	59170	$ 60,235	$ 264,848
Lowell House, Inc		$ 9,942	$ 19,162	$ 19,377	$ 19,723	$ 20,078	$ 88,282
Mental Health Association of Greater Lowell		$ 9,942	$ 19,162	$ 19,377	$ 19,723	$ 20,078	$ 88,282
Consortium Entity or Affiliated Partner							
Consortium Entity or Affiliated Partner							
Operational Infrastructure	$ -	$ 49,711	$ 95,810	$ 96,884	$ 98,616	$ 100,391	$ 441,412
TOTAL INVESTMENTS	$ 449,999	$ 524,992	$ 580,695	$ 397,321	$ 332,048	$ 272,013	$ 2,557,067

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	IT Staffing including Fringe	Recruit experienced IT Manager	11/01/17	12/31/17	IT Manager onboard and trained							
Technology	Development and Adaptation of E.H.R/Care Management System	Secure and Implement Appropriate Care Management Platform	11/01/17	10/01/18	Appropriate vendor selected to develop case management platform that meets specifications				Design of case management platform complete and system implemented			
Technology												
Technology												
Workforce Development	Recruitment Expenses	Appropriate administrative and clinical staff recruited to facilitate program design and initial engagement of members	11/01/17	05/31/18	Program Director recruited and trained				3 Case Managers, 3 Community Health Workers, 1 Intake Coordinator and 1 Lead RN Recruited and on-board			
Workforce Development	Recruitment Expenses	Develop long-term recruitment plan for clinical staff	01/01/18	03/31/18	Plan developed and approved				Relationship developed with training programs to facilitate ongoing recruitment of clinical staff			
Workforce Development												
Workforce Development												
Business Start Up Costs	Program Staffing including Fringe	Program Staff recruited, onboarded and trained prior to start of member assignment	04/01/18	05/31/18	n/a				Key staff in place to initiate engagement of members			
Business Start Up Costs	Program Staffing including Fringe	Roles and responsibilities of key staff defined to facilitate member engagement and management	02/01/18	05/31/18	Roles and responsibilities defined by Program Director				Standardized member engagement strategies developed across affiliated organizations			
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure		No operational expenses budgeted in prep budget period										
Operational Infrastructure												
Operational Infrastructure												
Operational Infrastructure												

BH Community Partner - Staffing Model

Greater Lowell BH Community Partners/ Lowell Community Health Center

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	750	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	1	*Total management oversight of BH CP*
3	Medical Director	0.25	*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs	1	*Lead RN*
5	Clinical Care Managers (RN)	2	*Do not include FTEs listed in line 4*
6	Clinical Care Managers (LPHA)	2	*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders		*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff		*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	13	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)	2	*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists	2	
12	Administrative Support	1	
13			
14			
	Total FTE	24.25	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1:250	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	1:4	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff: In our model of care, Community Health Workers will be supervised by the Care Coordinators that they work most closely with. Care Coordinators are either licensed BH or unlicensed BH staff, depending on the needs of the organization. All Care Coordinators will do this supervision. Care Coordinators will be supervised by either the Lead RN or in-kind staff in affiliated partners (Lowell House and Mental Health Association of Greater Lowell). The Peer Specialist and the Recovery Coach will be supervised by in-kind staff at the organizations. The Program Director and the Medical Director are available to all staff in support of member case reviews, skills development and consultations. The Lead RN, RN, Peer Specialist and Recovery Coach will support members and Care Coordination teams across all three affiliated partners.

Section 7.3 Initial DSRIP Participation Plan

A. Executive Summary

As the Lead Agency on this Request for Responses (RFR) submission to participate with the Executive Office of Health and Human Services (EOHHS) as a Behavioral Health Community Partner (BH CP), the Lowell Community Health Center (Lowell CHC) and two Affiliated Partners known as Lowell House, Inc. (LHI) and The Mental Health Association of Greater Lowell, Inc. (MHA) (Greater Lowell BH CP) represent three best practice Behavioral Health (BH) organizations in serving the Greater Lowell area.

The Greater Lowell BH CP partners bring over 300 years of experience in total providing evidence-based BH to residents in Northern Massachusetts. We provide data-driven BH care coordination, care management, and BH services and supports to more than 7,600 individuals with disabilities and mental health challenges annually, helping some of the most underserved consumers in the State live as independently as possible in the community, while achieving their wellness and recovery goals. We serve individuals with Serious Mental Illness (SMI) and Substance Use Disorders (SUD) as well as Long Term Services and Supports (LTSS) needs. The Greater Lowell BH CP seeks to improve member satisfaction, quality, and cost-effectiveness and are highly innovative in our approach to BH care delivery for underserved individuals.

1. Goals and Challenges

The Lowell CP goals align closely with the State's goals to:

- **Support individuals with high BH (and LTSS) needs** to help them navigate the complex BH system providing coordinated support services
- **Improve the Enrollee experience** by holistically engaging individuals with high BH needs with services that strengthen, enhance and diversify access for individuals and families we serve
- **Assist individuals in integrating into the community** through attaining valued community roles, active membership in local organizations and meaningful relationships
- **Incorporate an enhanced data-driven decision-making process** to guide clinical and administrative decisions to improve capabilities that enhance care delivery
- **Support community first values, SAMHSA recovery principles, and culturally competent care delivery** by adopting evidenced- based, best practices
- **Collaborate with ACOs, MCOs, CPs, and community organizations** to integrate care and address the social determinants of health

Challenges and solutions associated with meeting the State's BH CP Contract requirements:

Challenges	Solutions
Support true care integration	Utilize a single system that supports a full continuum of behavioral health care service and data integration among Affiliated Partners, ACOs, and others; Educate Enrollees and providers regarding integration

Challenges	Solutions
Connect Enrollees to Community-based Organizations (CBOs) to address social determinants of health	Leverage our close relationships with local organizations that serve BH CP Enrollees
Collaborate with multiple ACO Partners, each with different IT systems and processes	Work with ACO partners to create assessments and care plans and, to create a "bridge" between the ACO data system and the BH CP data system

2. Assigned and Engaged Enrollees

Greater Lowell BH CP currently serves an estimated 1,000 BH CP eligible Enrollees and has the capacity to support a total of 1,750 within the proposed Service Area. Greater Lowell BH CP is prepared to add capacity over the Contract period.

3. Service Area

Greater Lowell BH CP proposes to serve MassHealth Enrollees in the Greater Lowell area. Lowell CHC, LHI, and MHA are crucial organizations within the community, which is bound geographically by the Merrimack and Concord Rivers and surrounding elevations which, together create a naturally occurring community where local health care delivery is essential. For this reason, the Greater Lowell BH CP chose to bid on this single service area to serve Lowell residents, many of whom already utilize our facilities.

4. Plans to Operationalize the CP Program

To operationalize the CP program, we will engage in the following crucial implementation activities, based on time frames indicated below:

Activity	Timeline
Develop and execute contractual agreements with MCO and ACO partners	Upon Selection
Develop and implement Contractor Governance structure	Upon Selection
Identify, hire and recruit staff to meet all mandatory and other contractually required positions associated with the Contract	Throughout the Preparation Budget Period
Orient and train staff regarding Contract requirements	Within the Preparation Budget Period
Develop the process to accept Assigned enrollees from EOHHS and other referral sources and, to distribute appropriate materials; develop workflows associated with assignment/engagement	Upon Selection
Identify and develop general operational business functions	Upon Selection
Develop a Consumer Advisory Board consistent with Contract requirements	Within 60 days of Contract Execution
Develop, distribute and implement a Conflict of Interest policy	Within 60 days of Selection
Identify, secure and develop CP Support capabilities	Upon Selection
Develop and implement a comprehensive Quality Management (QM) Quality Improvement (QI) strategy	Within 90 days of Selection
Develop IT capabilities to track and report on Qualifying Activities included in the Contract including, but not limited to, IT testing and securing assurances	Upon Selection

B. Supporting Populations and Community Engagement

1. Community Connections

Health care is very local in Lowell, given geographic boundaries imposed by the Merrimack and Concord rivers and highways. Lowell CHC, LHI, and MHA share responsibility with many CBOs for delivering care to Lowell residents. Current and planned collaborations follow.

Community-based organizations: Our organizations actively collaborate with CBOs including, the Cambodian Mutual Assistance Association, Latin American Health Institute, MA Alliance of Portuguese Speakers, and the African Assistance Center. These relationships reflect the cultural and linguistic diversity of the population served by the Greater Lowell BH CP. We work with: Community Teamwork; Elder Services of Merrimack Valley; Renaissance Club; Merrimack Valley Legal Services; Family Resource Center; Boys and Girls Club; Lowell Senior Center; Lowell Transitional Living Center; Lowell Career Center; Merrimack Valley Food Bank; Learn2Cope; Center for Hope and Healing; The Merrimack Valley Food Bank; Lowell Adult Education; and UTEC, Lowell and area Police and Fire Departments, Health Departments, and Trinity EMS.

Advocacy groups: Our organizations will maintain ongoing collaboration with the Greater Lowell Health Alliance and the Substance Abuse and Mental Health Task Forces, the City of Lowell Youth Council the Association for Behavioral Health among others. All three agencies participate in the Middlesex Opioid Task Force, and GLEAN, a domestic violence high-risk team. Additional information regarding affiliations is available to EOHHS upon request.

BH providers: The Lowell CHC, LHI, and MHA refer individuals seen by Greater Lowell BH CP participants to the following BH and SUD providers: Lowell General Hospital, Circle Health Care Team, Lahey Behavioral Health, Children, Friend and Family, McPap, Center for Hope and Healing, Alternative House, Habit OPCO, Clean Slate, Bridgewell and Middlesex Recovery.

Housing/shelter providers: We work closely with the Lowell, Chelmsford, Westford and Tewksbury Housing Authorities, Community Teamwork, Alternative House, local sober houses, and the Transitional Living Center to support homeless individuals. We also have personal relationships with many Lowell area landlords. LHI has Residential programs, transitional housing, sober housing, and permanent housing supportive case management services.

Public agencies: The Lead Agency in this submission, the Lowell CHC, contracts with MassHealth as well as All MassHealth MCOs including Fallon, Neighborhood, Tufts, Celticare.

The Greater Lowell BH CP collaborates with MassHealth, Department of Public Health (DPH), Mass Rehabilitation Commission, Department of Developmental Disabilities (DDS), Department of Mental Health (DMH), Bureau of Substance Abuse Services (BSAS), Department of Children and Families (DCF) and others. We also work with the Department of Transitional Assistance; Department of Motor Vehicles, Middlesex Sherriff's Department; Department of Housing and Community Development; Offices of Adult and Juvenile Probation; and, local health departments.

2. Growing Community Connections

We will continue to expand such connections under the BH CP Contract. The Greater Lowell BH CP will achieve this goal by leveraging and building on existing relationships and, by identifying and pursuing new relationships as one means to enhance access, integration, and continuity for Enrollees. We will systematically identify where Enrollees receive services and continually seek Enrollee, family and community-based expansion strategies.

Participation in community health needs assessments: All three Greater Lowell BH CP organizations have participated in focus groups to share our views of community health status during the development of the 2016 Greater Lowell Community Needs Assessment.

Examples of successful community connections: Lowell House partnered in the development of the Community Opioid Outreach Program (COOP) in 2016, with the Lowell Police and Fire Departments, Lowell Health Department, Trinity EMS, and MHA. The COOP team has learned of and attempted outreach to at least 307 individuals in their homes. At least 104 people had follow-up visits with the team after initial contact. In addition, MHA works with these partners and the Middlesex DA's office on a program to support the children and family members of opioid abusers.

The Lowell CHC and LHI, in partnership with the Middlesex County Sheriff's Office, connects individuals reentering society after incarceration with primary, behavioral and SUD treatment if necessary. Through this partnership, we link individuals to needed services to prevent recidivism.

Link to Business Plan: One of Greater Lowell BH CP's organizational goals is to grow our collaborative efforts with CBOs over the course of the BH CP Contract. To meet this goal, we will implement initiatives that address social determinants of health, partnering with local, CBOs that address Enrollee's needs for housing, food, safety and other issues.

3. Informing Staff of Community Resources

Informing Staff Regarding Community Resources

Greater Lowell BH CP will ensure that staff fully understands community resources to meet the needs of our BH CP Enrollees. We will update information as changes occur in a shared electronic database. Our plans to inform and update staff follow:

Community resource guide: Greater Lowell BH CP will develop and maintain an electronic and hard copy community resource guide as a reference for staff.

Staff training: We will organize and conduct on-going educational sessions for staff to support collaboration with CBOs including information on community resources and updates. Our organizations will jointly hold staff conferences with invited CBOs and guest speakers. We will hold grand rounds within the Lowell CHC will include updates and training on evidence-based best practices, and best practices in CBO supports.

Interdisciplinary Care Team meetings: All three participating Greater Lowell BH CP partners will utilize some portion of the ACO's ICT meeting times to educate staff on the BH CP program.

C. Community Partner Supports and Activities

1. Outreach and Engagement

a. Planned strategies for outreaching to and engaging with Assigned Enrollees, including individuals homeless and hard to reach individuals

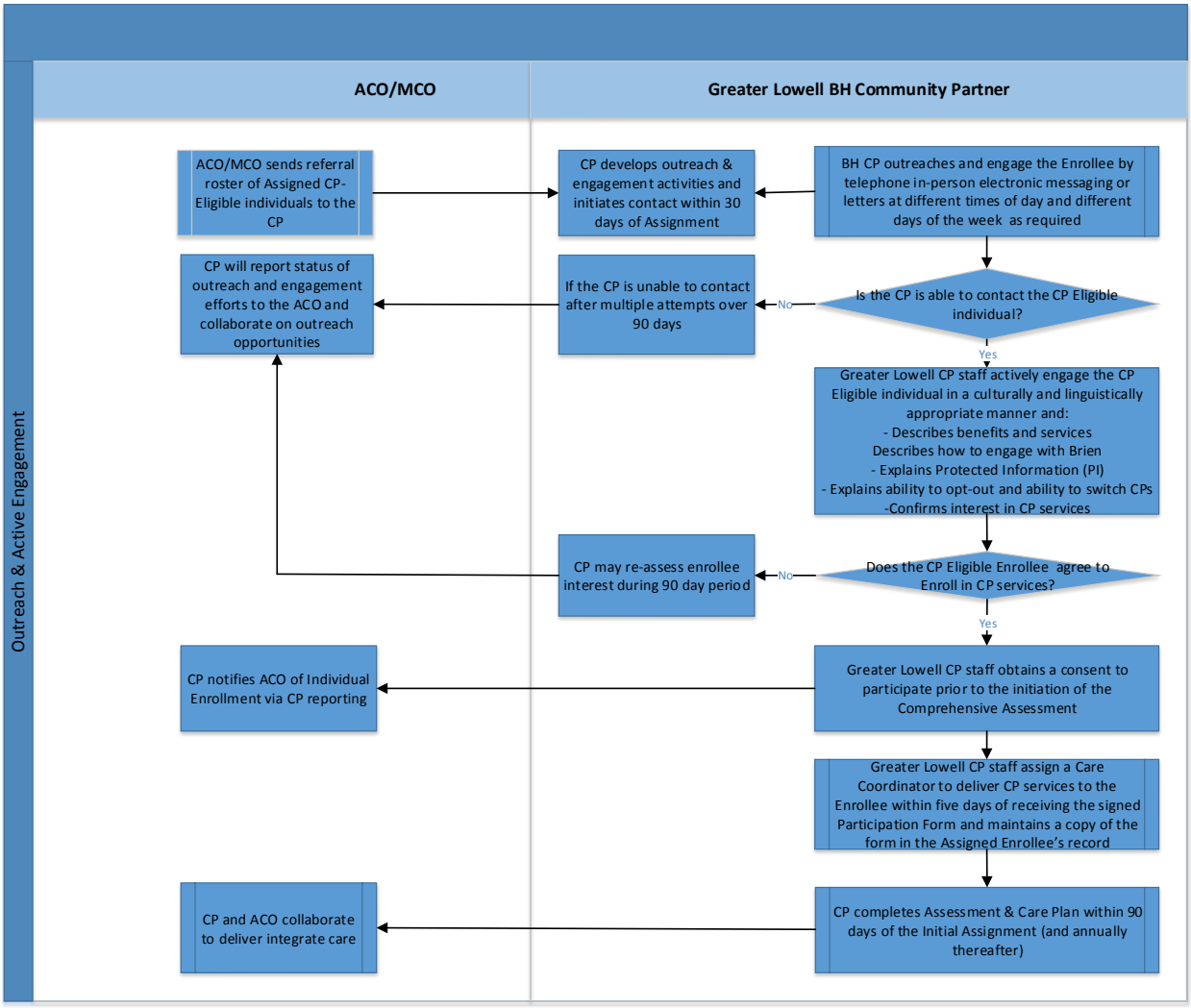
The Greater Lowell BH CP provides key access points to services in the Lowell area. Between our three agencies, we will identify and engage many Enrollees through our provided services as a part of our daily operations. For these cases, personnel within each agency will work closely with the BH CP care coordinator. The Greater Lowell BH CP subscribes to Substance Abuse and Mental Health Service Administration's (SAMSHA) philosophy and approach to locate, outreach and engage Assigned Enrollees who have not otherwise been engaged in services. This philosophy begins with our learning about the Enrollee's current BH provider relationships and the importance of meeting the Enrollee's basic needs. As we initiate contact with the Enrollee, we begin building rapport and trust, focusing on strategies to connect Enrollees to services without making them feel uncomfortable, judged or threatened. Key outreach strategies are as follows:

Greater Lowell BH CP meets the Enrollee at any available location in the community where the individual is personally comfortable, which may include but not be limited to their home, neighborhood locations, tent cities, motels, shelters, or congregate meal sites among other locales. We seek to truly connect with the Enrollee and build trust, regardless of where we physically meet. We feel strongly that asking the Member to select the location that would be most comfortable for them is an important step toward building the Enrollee's confidence in the BH CP and trust. Our knowledge of the Greater Lowell community and culture is a great asset in approaching this important strategy.

Our organization makes the process of building a relationship with the Enrollee as primary and does so by being highly respectful toward Enrollees and their families. We seek to create an open, safe, friendly environment that is trauma-sensitive in which to meet. And, we immediately seek to assess and meet Enrollee's basic needs.

We hire highly qualified, skilled individuals who are trained in motivational interviewing and are very skilled at engaging and interacting with individuals who have SMI and SUD diagnoses. Furthermore, we hire staff who are experienced in serving the target population and understand their needs and preferences that go well beyond cultural and linguistic needs. **Figure 1** illustrates the Outreach and Engagement process.

Figure 1. Outreach and Engagement Process



Our primary strategies to outreach and engage Enrollees, including individuals who are homeless, reflect the philosophy and strategies described above. For individuals who are homeless, our efforts notably include direct community outreach in areas where homeless individuals congregate and live, including tent cities, under bridges, in downtown areas, outside shelters, and at Living Waters Drop-in Center.

The Greater Lowell BH CP will employ specialized Intake Coordinators, to conduct outreach to and connect with Eligible Enrollees, supported by our BH CP Care Coordinators and Community Health Workers as needed. The goal of this initial outreach will be to welcome the Enrollees to our program, explain the benefits and schedule the first in-person contact BH CP Care Coordinators and Community Health Workers. We will make a minimum of one outreach activity to each assigned Enrollee within one month of receiving an Assignment from the ACO. In practice, we will attempt to reach the Enrollee several times by phone within 30 days of Assignment. While we will normally contact Enrollees in the community, if an Eligible Enrollee is

hospitalized, we will attempt to make the first in-person contact during an acute care event at the hospital, taking care to ensure that the Enrollee is comfortable. In this manner, we will proactively participate in the Enrollee's transition of care at the outset of their enrollment. Whenever possible, based on the Enrollee's willingness to meet, we will meet with the individual face-to-face within the first three calendar months of the Enrollee's assignment. If the Enrollee is not willing to meet, we will continue to identify opportunities to introduce BH CP services. Enrollees will also be able to request assignment to a different staff member within our organization or assignment to a different BH CP organization at any point in time.

We will make every effort to contact Enrollees who cannot be reached telephonically by going to community locations where we know we may locate the individual (e.g. at home, at a congregate meal site, etc.). We will make at least three attempts to establish contact and anticipate that we may need to make several attempts to contact an Enrollee to schedule a time and location for an initial meeting.

Our staff will meet with the Enrollee in a location, and at a time that is most comfortable for the individual with a family member or caregiver, if desired by the individual. If agreed to by the Enrollee, we will meet with him/her in their home to obtain insight into the Enrollee's social determinants of health and home safety.

At our initial meeting, the Greater Lowell BH CP staff will provide Enrollees with introductory materials including information regarding the benefits and the design and purpose of BH CP supports. This information will be offered in written and verbal formats and will be available to Enrollees' in their primary preferred language for the most commonly spoken languages among the population served.

We will provide information regarding the BH CP service delivery process to help the Enrollee understand how to engage with our organization and will explain that the Enrollee can opt out of receiving BH CP services at any time. We will further provide information regarding how to reach our website, participate in the Consumer Advisory Board, and contact a BH CP Care Coordinator or Community Health Worker or Community Health Worker.

During the first in-person contact, The Greater Lowell BH CP staff will employ motivational interviewing to understand the Enrollee's health status, their needs and preferences and, their aspirations and/or frustrations with barriers to care delivery that require attention. At a minimum, the Care Coordinator will describe benefits and services, describes how to engage with Greater Lowell BH CP staff, explains Protected Information (PI) and the purpose of this practice; explain the individual's ability to opt-out of BH CP services as well as the ability to switch CP agencies entirely. Ultimately, the Care Coordinator will confirm the Enrollee's interest in CP services and obtain a signed Participation Form, which will be filed in the Enrollee's records.

After the Participation Form is signed, we will perform the Comprehensive Assessment and work to truly understand the Enrollee's needs and preferences in their primary preferred language with attention to cultural beliefs. Individuals who choose not to enroll will be provided with

contact information should the individual choose to enroll later, and will be asked if periodic outreach from an advocate is acceptable.

Where possible, and when desired by the Enrollee, the individual who performs the initial contact and assessment will serve as the BH CP Care Coordinator or Community Health Worker and take a leadership role in delivering services as part of our BH CP team. If the Enrollee prefers a different Care Coordinator or Community Health Worker, another staff member from our organization will be assigned based on the Enrollee's preferences.

b. Planned Strategies for Outreaching to, and Engaging with, Assigned Enrollees with SUDs

We will tailor our approach to outreaching Enrollees with a SUD diagnosis based on his/her readiness to participate in treatment, utilizing a harm reduction approach. We will engage Enrollees with SUD diagnoses by assigning staff with appropriate expertise including cultural and linguistic alignment, and use staff who have lived experience and are in recovery using a process that resembles the contractually required process described above.

The Greater Lowell BH CP will emphasize the relationship development process as primary in the CP service delivery process for individuals with SUD and other diagnoses, as described above. As is the case today, our staff will continue to be highly respectful toward Enrollees and their families regardless of the struggles associated with their diagnoses. We seek to create an open, safe, friendly environment in which to meet without judgment regarding substance use and will provide appropriate services if the individual is actively using substances. And, we will immediately attempt to assess and meet Enrollee's basic needs to gain their trust and, to provide immediate and tangible support as needed. We will seek to address their housing, food, medical issues, and safety as basic needs from the outset.

c. **Planned Process to Obtain and Document Assigned Enrollee's Agreement** to Participate in CP Supports Through a Participation Form

At the initial visit, prior to the assessment, each Enrollee will be asked to sign a participation form. Our staff will thoroughly explain the purpose of the participation form to the Enrollee and confirm their desire to participate in the BH CP program. We will further explain the concept of protected information and how we intend to gather, store, utilize and protect any information provided by the Enrollee. The BH CP Care Coordinator or Community Health Worker will explicitly inform the Enrollee, in their primary preferred language and in a cognitively appropriate way, so that the Enrollee can fully comprehend why we need to obtain their written authorization to provide quality CP support services.

Following receipt of the participation form, we will formally assign a BH CP Care Coordinator or Community Health Worker within five business days of receipt of the signed participation form. A copy of the form will be maintained in the Enrollee's record.

2. Comprehensive Assessment and PCTP Development

a. Process for Conducting Comprehensive Assessments

We place the Enrollee at the center of the assessment and treatment planning processes and constantly engage them to identify their needs, priorities, and preferences. Our assessment process will begin with a review of medical records and any available documentation regarding the Enrollee's needs and condition by one of our registered nurses, who is a part of our clinical team. Specifically, staff will review the Enrollee's medical history, medical needs, and medications and will summarize them for our BH CP Care Coordinator or Community Health Worker, prior to completion of the full Comprehensive Assessment. Our Clinical Care Managers will review the final assessment upon completion.

Starting in budget year 1, we have budgeted funding for additional Comprehensive Assessment support through contracted entities. These additional, dedicated contract staff resources will enable us to complete the comprehensive assessments and engage members quickly in the BH CP to meet their needs most efficiently.

If the Enrollee has an existing relationship with a Primary Care Provider (PCP), state agency care/case managers or other treatment providers, we will engage these key individuals in the Comprehensive Assessment and the PCTP processes at the outset. We anticipate involving DMH, BSAS and others in the treatment process, seeking to eliminate duplication and conflicting efforts where all care management supports are seeking to support the Enrollee's primary, stated goals and needs.

The Greater Lowell BH CP's goal is also to leverage any information already collected by the Enrollee's ACO partner. We believe this is important to maintaining a person-centered, efficient process that minimizes duplication and demands on the Enrollee. We are already engaged in conversations with the potential ACOs in our geographic area regarding information sharing strategies to inform the Comprehensive Assessment and other processes. We hope to work with the ACOs in our region to develop a single integrated assessment that builds on information already obtained from the Enrollee. Gathering the same information from the Enrollee or other sources could be disruptive to the Enrollee as well as wasteful and inefficient.

Ideally, with the Enrollee's permission, we will incorporate any available data from the ACO into the BH CP Comprehensive Assessment. Our Care Coordinator will then meet with the Enrollee to complete the BH Assessment, following the Enrollee's signing of a Participation Form, and specifically assess the Enrollee's immediate care needs, current services, personal and familial medical history, medications, health communications skills, existing primary care utilization and emergency department utilization history with a specific focus on BH and SUD needs and preferences. At the same time, our Care Coordinator or Community Health Worker will also reach out to the ACO Care Manager to integrate across physical, BH and other care needs together, in a team-oriented manner. We will participate on the Enrollee's ACO Care Team if possible, with the goal of jointly preparing a truly integrated Comprehensive Assessment.

Following the completion of the Comprehensive Assessment by the Enrollee's Care Team, ACO and other key providers, we will communicate the results of the Assessment to the Team and jointly determine implications for on-going care planning.

The Greater Lowell BH CP will use a combination of the Massachusetts Standardized Data Project (MSDP) forms to perform Comprehensive Assessments for BH CP Eligible individuals. We agree to meet all EOHHS requirements pertaining to mandatory data elements mandated in the Model Contract. We will select appropriate forms based on adult, child/adolescent, SMI or SUD status. Our goal is to maximize person-centeredness, minimize duplication and maximize efficiency. We plan to review and discuss the MSDP tools, included as Attachment 7.3.C to this RFR submission with local ACOs, prior to sharing our final selection of forms with EOHHS. The attached MSDP forms include a Comprehensive Assessment for Adults, a Physical Health Assessment (in the event that such information is not available from the ACO); a Child and Adolescent Assessment; and an Addictive Behavior and Substance Use History Addendum.

b. Process for Conducting PCTPs

After the Comprehensive Assessment is completed, our BH CP Care Coordinator will use the assessment data, combined with other available information (e. g. medical records information and other relevant data) to develop the PCTP with the Enrollee. We will seek to develop a truly integrated PCTP that addresses each Enrollee's medical, behavioral, substance use and psychosocial support needs. The Greater Lowell BH CP will employ specialized staff to serve individuals with SUD diagnoses including Recovery Coaches as well as Peer Specialists to assist in the care of members with SMI.

The BH CP Care Coordinator and/or Community Health Worker will collaborate with the Enrollee and their family member or informal caregiver to create a truly person-centered plan that reflects the Enrollee's needs, preferences, and goals. We will encourage the Enrollee to take a lead role and making sure the individual can develop their PCTP goals.

As stated above, we will seek to participate in the ACO or MCO Interdisciplinary Care Team (ICT) meeting for individuals that we serve. We will also consistently invite the ACO to participate in BH CP Enrollee care plan meetings. Regardless of who requests the meeting, a The Greater Lowell BH CP Care Coordinator will seek to lead an integrated discussion of BH CP needs, rather than requiring the Enrollee to attend separate meetings with their ACO and our BH CP staff.

If the ACO does not plan to hold a meeting to discuss the Enrollee's PCTP, we will hold a separate meeting to discuss the Enrollee's BH needs and will invite the ACO or MCO to participate. If the Enrollee prefers a separate meeting specifically to discuss their BH needs, we will offer a session with the Enrollee's BH CP Care Coordinator or Community Health Worker and other BH CP Care Team members as requested. Regardless of when this initial meeting is held, we will complete the PCTP within three months of the Enrollee's assignment to The Greater Lowell BH CP.

The BH CP PCTP will include, but is not limited to: Enrollee goals and objectives, specific action steps to achieve goals, a method for tracking goal progress, referral needs to obtain care and services, educational needs, and any other necessary information. PCTPs may also include a crisis

plan, especially for individuals with BH needs with a history of crisis service utilization. The Person-Centered Treatment Plan (PCPT) will include actionable steps, responsible parties and timeframes for implementation.

Planned processes for documenting the PCTP. The Greater Lowell BH CP Person-Centered Treatment Plan will be documented in the integrated case management platform selected by and implemented across the three organizations in the BH CP. We intend to build interfaces across systems and to the Mass Hi-Way to assure the PCTP can be easily shared across providers with enrollee consent.

We will provide our care coordination staff with tablets, smart phones and other mobile technology to facilitate engagement of the enrollee in the PCTP process in community locations most convenient and comfortable for them.

Planned processes for updating the PCTP. The Greater Lowell BH CP Care Coordinator will update the PCTP in collaboration with the Enrollee, their family member/caregiver, the ACO and other key stakeholders identified by the Enrollee. Our BH CP Care Coordinator, in collaboration with the Registered Nurses and other members of the care team, will be responsible for updating PCTPs at any major change in the Enrollee's condition (e. g. loss of housing, loss of informal caregiver, BH crisis, new BH diagnosis, BH or medical hospitalization, multiple ED visits) progress toward treatment goals, a decline in functioning, or transition between levels of care. If the Enrollee's quality of life is not improving or the Enrollee feels that the plan needs an update, we will also update the PCTP.

The BH CP Care Coordinator will share PCTP updates with the Care Team within the Enrollee's ACO and, internally within the BH CP. Recognizing that Enrollee's needs are fluid, our BH CP Care Coordinator and Community Health Worker will review the PCTP and the Enrollee's progress during each interaction and inform key stakeholders as necessary and appropriate while respecting the Enrollee's privacy and wishes.

The Greater Lowell BH CP will complete thorough re-assessments which will include, but are not be limited to: updates that review past progress toward goals, health status, future goals, monitoring of compliance with the PCTP, recommended follow-up and a complete update to the PCTP. Each time a re-assessment occurs, or if the PCTP changes because of a review, we will update and distribute the PCTP appropriately. We will conduct reassessments and update to the PCTP at least every year and following a change in Enrollee status that is self-limiting, impacts their health status and requires a review.

We will develop a process that is consistent with the creation of the original PCTP where the Enrollee and the PCP approve the PCTP prior to implementation. We will further review and provide a copy of the Plan to the Enrollee and the PCP upon completion.

Ensuring the Assigned Enrollee and PCP or PCP Designee approve the PCTP. Ideally, the PCTP will be developed by the BH CP with input from the ACO ICT, if an ICT is in place. The BH CP Care Coordinator will review the PCTP and other information with the Enrollee including but not

limited to, the Enrollee's right to appeal any denial, termination, suspension or reduction in services or any change in providers, services or medications included in the PCTP. The Care Coordinator will inform the Enrollee of their right to approve the PCTP and obtain such approval. The Greater Lowell BH CP intends to obtain sign-off from the PCP who will receive a copy of the PCTP upon completion. Upon Enrollee and PCP approval of the PCTP, the BH CP will provide the Enrollee and the full team with a copy. The Greater Lowell BH CP will coordinate care with the PCP and Care Team based on the PCTP.

If the ACO is unable to develop the PCTP directly in collaboration with the Enrollee and the BH CP, the BH CP Care Coordinator or Community Health Worker will share the PCTP with the Assigned Enrollee. All BH CP Assessments will be reviewed and approved by one of our staff registered nurses working with the BH CP care teams.

3. Care Coordination and Care Management

a. Identifying All Stakeholders Involved in an Enrollee's Care

The Greater Lowell BH CP will identify all stakeholders involved in the Enrollee's care through multiple methods. First and foremost, we will ask the Enrollee which individuals they most want to be involved in the care team. Our BH CP Care Coordinator or Community Health Worker will contact the individuals' PCP, involved State agencies and community-based organizations who are involved in the Enrollee's care. The Greater Lowell BH CP staff will also contact the Enrollee's ACO to determine what care management efforts are underway so that care is fully integrated and coordinated and, no duplication of service delivery occurs.

The Enrollee's Care Coordinator will assemble an ICT that includes, but is not limited to: the PCP, The Greater Lowell BH CP's Clinical Care Manager, the Enrollees' Care Coordinator and Community Health Worker, and the individual's BH clinician and others as appropriate (e.g. family, caregivers, advocates, state agency staff or other care managers). We will also include LTSS providers who are aware of the Enrollee's LTSS needs and preferences and will counsel the Enrollee regarding LTSS options, including a choice of at least two LTSS service providers. Likewise, our BH CP Care Manager will facilitate access to, and the delivery of LTSS for eligible individuals and will assist in servicer navigation.

b. Exchanging Information with Such Stakeholders

The Greater Lowell BH CP will share information with stakeholders verbally and in writing. We will hold community meetings and visit key community partners to explain the use of BH CP services. Each time we integrate care for an Enrollee, we will educate stakeholders regarding the relationship between BH CP services and the services that they provide.

c. Identifying and Organizing Members of the Enrollee' Care Team

The Greater Lowell BH CP describes our process to identify members of the Enrollee's Care Team in response 3.a above. Our goal is to be available to the ACO or MCO's team and/or to facilitate a meeting of the Enrollee's full team (e.g. including not just our BH CP Care Team but the entire ICT, including the Enrollee and family or caregivers, if appropriate) to participate in the

development and implementation of a fully integrated person-centered assessment and PCTP for each BH CP eligible Assigned Enrollee.

d. Ensuring Effective Ongoing Communication Across All Stakeholders

The Greater Lowell BH CP will assure effective ongoing communication across stakeholders through multiple means. First, we will maintain close contact with the Enrollee to ensure that the individual's needs and preferences are met. In addition, we will regularly communicate with the Enrollees' PCP and key agency and community-based caregivers to ensure coordination and integration. While we plan to participate in, or hold, an ICT meeting to initially create a PCTP to meet the Enrollee's needs, we will reach out to key stakeholders telephonically as needed and initiate ICT meetings when appropriate and necessary.

To make sure that Enrollee's needs and preferences are addressed, we will share the PCTP with the Enrollee and their family or informal caregiver, the Enrollee's PCP, specialist and other providers or key stakeholders. We will further coordinate medical, prenatal, outpatient BH and preventative care reminders with the ACO. We will assist Enrollees in scheduling medical and BH appointments and, will conduct follow-up in collaboration with the ACO or MCO, to ensure that appointments are kept and, that the Enrollee's situation has not changed.

The Greater Lowell BH CP will select an information technology vendor to provide a communication platform between care settings, including between providers in different ACOs with whom we will partner. The system will be selected by competitive bid, configured and implemented in the preparation period.

4. Care Transitions

The Greater Lowell BH CP is aware that transitions of care represent an important opportunity to promote quality, Enrollee satisfaction and cost-effectiveness of care delivery. We will deliver transitional services to assist the Enrollee successfully transition from a hospital, skilled nursing facility or rehabilitation stay to their chosen living situation. In establishing a strong transition to the community, we will further seek to proactively plan services and supports and avoid or decrease unnecessary Emergency Department (ED) visits or hospitalizations. Our goal is to support the Enrollee's ability to live successfully in the community, in the setting of their choice.

We will participate, in collaboration with the ACO or MCO and other providers, in transition planning prior to an inpatient discharge. We will maintain strong relationships with the ACO or MCO, participate in discharge planning meetings and follow-up with hospitalized Enrollees through a face-to-face visit that will occur within three business days following discharge. We feel strongly that visits to Enrollees who were recently hospitalized must be coordinated with the ACO or MCO so as not to overwhelm them.

As part of the transitions process, we will update the PCTP and coordinate clinical and support services as needed. We will further assist the Enrollee to access additional supports from providers (with warm hand-offs as needed and appropriate) and follow-up to ensure that the Enrollee attends the appointment. Where Enrollee's miss appointments, we will address any barriers to care, such as providing transportation assistance.

5. Medication Reconciliation

The Greater Lowell BH CP adheres to evidence-based practices in all aspects of care management, transition planning, and medication administration. Our registered nurses, active members of the Enrollee's Care Team, will perform medication reconciliation as part of transition planning upon discharge, and at appropriate times when delivering BH CP services. We will contact the Enrollee's PCP to verify medication orders and will review with the Enrollee, whether all prescriptions were filled appropriately.

Our BH CP Care Coordinator or Community Health Worker will review medications during the transition visit within three days of discharge and will assist the Enrollee in adhering to their medication regimen. The BH CP Care Coordinator or Community Health Worker and the registered nurse will identify additional supports to assist the Enrollee with taking medications appropriately. If the Enrollee is in a Medication Assistance Program (MAP), the BH CP will work with the Enrollee's PCP to update the medication order forms with the MAP provider.

6. Health and Wellness Coaching

a. Health and Wellness Education, Coaching and Health Promotion Programs

The Greater Lowell BH CP believes that evidence-based health and wellness promotion activities are an integral component of improving the overall wellness and recovery for individuals with SMI and SUD and related disorders.

As described in our response to Section 7.2.D.2, we have significant experience providing health and wellness education to our Enrollees. For example, we maintain an active Health and Wellness Committee, provide staff training in Executive Order 509 nutrition standards with many programs offered related to nutrition, connect Enrollees to tobacco cessation programs, and educate Enrollees on self-management of chronic medical conditions. We will leverage our experience and existing processes to establish a comprehensive, evidence-based Health and Wellness program that meets or exceeds the requirements detailed in Section 2.3.F of Attachment A.

In our experience, some Enrollees have a greater need for health and wellness education, coaching, and intervention than others. In some cases, general educational information will suffice. In others, such as when an Enrollee is significantly overweight, sedentary, or is struggling with tobacco use, more intensive interventions may be required. For these Enrollees, we will offer wellness programs of longer duration (3 or more months), which combine education and activity, and incorporate both nutrition and physical exercise are more likely to be effective than are programs of shorter duration, those focusing only one factor (e.g. nutrition or exercise), or unstructured, education-only programs. As a BH CP, we will establish collaborative Health and Wellness programs with ACOs.

b. Methods for Ensuring the Engaged Enrollee's Goals for the Health and Wellness Programs Are Recorded and Tracked

As part of the Comprehensive Assessment, we will evaluate the Enrollee's need for Health and Wellness information, coaching, or other interventions. We will identify any high-risk behaviors, including poor nutrition, overweight or obesity, lack of exercise, and other risk factors and share this information with the Care Team, and the Enrollee's ACO. The Enrollee's self-identified goals and objective for addressing these needs will be documented in the Enrollee's PCTP. The Care Team will monitor Enrollee's participation in recommended Health and Wellness program(s), and periodic updates will be provided to the Enrollee's ACO Contact Person or Care Management Team.

7. Connection to Community and Social Services

a. Plans to Evaluate Engaged Enrollees for Social Service Needs

The Greater Lowell BH CP employs a person-centered approach that considers the total care needs of Enrollees with SMI or SUD. As a BH CP, we will foster an integrated system of care by collaborating with medical providers, Care Managers, ACOs, and other stakeholders, beginning with a Comprehensive Assessment to identify, among other needs, social service needs that can be met by social services and supports agencies.

Our assessment tool, which will be approved by EOHHS prior to use, will assess such needs as housing, utility assistance, social and cultural engagement, employment services, transportation, child care, food and nutrition supports, physical security, and any additional Flexible Supports that an ACO partner identifies.

As described in response to Section 7.3.B. above, The Greater Lowell BH CP's has long-standing relationships with community and social service agencies in our service area and will leverage these relationships to ensure Enrollee access to needed supports and Flexible Services.

b. Ensuring Care Coordinators are Familiar with a Wide Breadth of Social Services and Supports, and Providers of These Supports

The Greater Lowell BH CP currently has processes in place to refer to and coordinate with community services providers and social service agencies. We will use these existing processes to facilitate ongoing communication and information-sharing and ensure that Enrollees have timely access to needed community supports.

Our formal current and planned approaches include:

- Developing comprehensive referral and community resource guides for Engaged Enrollees and ACO staff
- Appointing dedicated points of contact for ACOs and MCOs
- Executing memoranda of understanding with providers and community organizations regarding the delivery and coordination of services
- Appointing liaisons to foster relationships and communication with community agencies

c. Planned Strategies for Collaborating with ACOs to Recommend Flexible Services

We will jointly develop processes and procedures with ACOs in our service area to coordinate access to Flexible Supports authorized by the ACO. Care Managers will work with ACO Care Managers for Engaged Enrollees to identify supports (as documented and authorized by the ACO) and jointly establish a plan for providing or arranging for them (as appropriate). These services will be included in the Enrollee's PCTP and monitored by the Care Team. Specific strategies for collaborating with ACOs and MCOs include:

- Upon the execution of the partnership, we will orient the ACO to our organization, services provided or facilitated, structure and operations of our Care Team model, and provide contact information.
- Establish and facilitate a joint Care Coordination Planning Committee to develop processes and procedures to ensure communication and collaboration between the two organizations' care management teams.
- Establish and maintain periodic joint care management meetings (telephonic, WebEx, face-to-face) to ensure appropriate communication, collaboration, follow-up, and accountability.
- Develop and maintain a common community resource directory for use by Enrollees and staff.
- Conduct joint training (initial and periodic) for care management, care coordination staff.
- To the extent allowed by the Enrollee, share care plans, progress reports, status reports, and other pertinent information about Engaged Enrollees with the ACO.

D. Innovative technologies for service delivery

Lowell CHC and our Affiliated Partners are proficient in the use of technology to facilitate consistent and accurate documentation and provide effective and efficient services to Enrollees in their homes and community settings. The Lowell BH-CP have technology solutions in place to support their day to day operations. In the case of Lowell CHC, it uses eClinicalworks to support the delivery of integrated care. Lowell House uses Credible Software which is designed for behavioral health documentation. Mental Health Associates of Greater Lowell uses Netsmart which is also designed for behavioral health documentation. The technology solutions all have the capability to exchange information via HL7 interfaces. This will allow the Lowell BH-CP to implement a care management tool which will be able to support information exchange using this industry standard.

Lowell CHC as an example has leveraged its electronic health record platform to support activities such as home visits. Community Health Workers can access the electronic record via secured connection to retrieve information and document their encounter. The health center has recently piloted the use of Apple iPad tablets to enhance the staff and patient experience. Additionally, Lowell CHC has deployed iPads to assist with patient interpretation using video. This is particularly important for patients who communicate via American Sign Language.

The health center has robust clinical informatics reporting capabilities which allow the generation of patient population reports. Specifically, Lowell CHC has been working with the Massachusetts League of Community Health Centers and Azara Healthcare to develop a clinical reporting tool which allows the health center to have a clinical outcomes dashboard. This tool also allows the health center to compare itself to almost 50 other community health centers.

As the lead agency, Lowell CHC will work with its Affiliated partners to share best practices and offer technical assistance to ensure that all elements associated with technology and innovation are in alignment with the model of care requirements.

Additional information and sample reports are available upon request from EOHHS.

E. Personnel and staffing

1. Organizational Chart

We provide our organizational chart as **Attachment 7.3.E-1** to this RFR submission, identifying personnel who will be assigned to accomplish the Contractor responsibilities described in Attachment A of the RFR.

2. Sample Staffing Model

We propose serving 1,750 BH CP eligible Enrollees within our overall Service Area, as detailed in **Attachment D**. Capacity and staffing will grow over time, starting with capacity for 750 Enrollees in year 1. Our staffing model will include the following positions and number of full-time equivalents (FTEs). Administration positions will support all affiliated partners and will be hired in the preparation budget period or year 1. Care Coordination staff will be hired on a rolling basis, aligned with increases in membership throughout the first four years of the program.

Table 7.3.E.2. Staffing Model

Position	**FTE**
Administration	
Director of BH Community Partner	1.0
Intake Coordinator	2.0
Medical Director	0.25
Data Analyst	0.5
Quality Improvement Coordinator	0.5
Administrative Assistant	1.0
Supervision	
Lead Registered Nurse	1.0
* Care Coordinators have supervision responsibilities for Community Health Worker staff	
Care Coordination Staff	
Registered Nurse	3.0
Licensed Clinical Social Worker	2.0
Care Coordinator	9.0

Community Health Worker	20.0
Peer Specialist	2.0
Recovery Coach	2.0

The approximate ratio for Care Coordination Staff is 1:57 Enrollees for direct case management, ratio is 1:46 enrollees including all supportive care coordination roles.

3. Recruitment Plans

Upon award and we will begin recruitment for the management, clinical care, nursing and care coordinator positions. Working with the ACO/MCO's to determine Eligible enrollee numbers and geography in our service area to aid in planning for the care management staff needed for program launch in April. We will expand partnerships with local colleges to recruit using programs that include career fairs, internships, shadowing, and may include innovative programs like student loan payment stipends.

The Greater Lowell BH CP anticipates starting the program with care management staffing that includes: one Lead RN, one Registered Nurse, one LCSW Clinical Care Manager, three Care Coordinators, one Clinical Care Manager, one RN, three Care Coordinators, eight Community Health Workers, one Peer Specialist and one Recovery Coach. We will continue to recruit for positions in advance of program growth, using the budget periods as milestones for assessment of enrollment and attrition rates, so that all staff is appropriately trained before they interact with individuals served.

One approach that this team will employ is utilizing the Recovery Coaching Model and hiring trained recovery coaches. The Recovery Coaching Model is a model that is derived out of the research that peer support facilities recovery and reduces health care costs (SAMSHA). SAMSA has provided a definition of recovery that includes not only a persons' sobriety or abstinence from a substance but is a broader definition that encompasses an individuals' overall health, home, purpose, and community. The Recovery Coaching Model aims to address all of these domains with each person in an individualized way.

Initial Recruitment Plan		
Position	**Begin Recruitment**	**Target Hire Month**
In-kind Senior Management Positions Required by the RFR in Section 7.2.B.	Already in place	Already in place
Director of BH CP Services/Care Coordination	October 2017	December 2017
Lead RN	January 2018	March 2018
Registered Nurse	March 2018	May 2018

Care Coordinators/Community Health Workers	March 2018	April/May 2018
Recovery Coordinator/ Peer Specialists	March 2018	May 2018
Application/Intake Coordinators	March 2018	May 2018
Admin Assistant	December 2017	January 2018
Data Analyst and QI Coordinator	May 2018	June 2018
Intake Coordinator	March 2018	May 2018

The Greater Lowell BH CP will seek candidates that possess academic credentials and/or applicable experience in clinical settings, community health work, peer specialists, and /or recovery support as well as knowledge and experience of local resources, BH and SUD treatment systems. We will further identify and recruit candidates whose share racial, ethnic, linguistic and geographic characteristics of the population served.

Job descriptions are provided as Attachment 7.3.E-2.

4. Recruitment and Hiring from Cultural and Linguistic Communities Served

Greater Lowell BH CP is committed to ensuring that staff is representative of the communities we serve. We recognize that "culture" encompasses more than linguistic diversity, and includes racial or ethnic background, national origin, immigration/refugee experience, physical or mental disability, gender and gender identity, and sexual orientation.

To that end, we take care to ensure that our providers, staff, and volunteers are responsive to the linguistic, cultural, ethnic, or other unique needs of all Enrollees. We will assess our current capacity and competencies through an initial survey of provider and staff relative to Community Partner Supports and cultural diversity. We will also utilize existing community needs assessments and studies, and will work with our ACO and MCO partners to maintain ongoing demographic, cultural, and epidemiological profile of the community. This information will be used to identify both hiring priorities, and training needs to increase sensitivity to the needs of individuals from different cultural and ethnic backgrounds. We will work closely with community-based organizations (e.g. immigrant and refugee coalitions, advocacy coalitions, LGBTQ advocacy agencies) to identify and leverage opportunities for targeted recruitment activities. We will also partner with ACOs and MCOs to conduct job fairs in specific communities and in languages other than English (where possible).

Starting in Budget Year 1, we allocated funding for interpreter services to support member engagement when we are not able to match the enrollee with a care coordinator or resource person who speaks their language.

We recognize that recruitment of a diverse BH workforce – particularly though not exclusively for substance use – is a nationwide challenge, with numerous systemic barriers that will be difficult to overcome. To that end, over the life of the contract we will evaluate the utilizing

DSRIP funds for short-term workforce development strategies (for example, signing bonuses for employees from underrepresented communities), and implement a longer-term initiative to review and potentially augment our staff retention programs, including ongoing career development, educational assistance, ongoing on-going licensing and credentialing opportunities, and leadership training.

5. Proposed Training

Greater Lowell BH CP participants manage training programs for our staff that help staff understands the needs of high-utilizing individuals with SMI or SUD. As we do today, we will train our CP staff on person-centered strategies to care for individuals with SMI and SUD with a focus on integration. We will leverage existing training modules to develop comprehensive CP training. We will also provide refresher training, as well as updated training on best practices, at least annually. We will finalize training modules and training schedules prior to the contract effective date. Below are examples of potential training modules:

Listing of Proposed Training Modules	
Understanding and awareness of the needs of high-utilizing individuals with SMI or SUD	· Chronic Illnesses and SMI/SUD · Recovery and Resiliency · People with Intellectual, Cognitive, and Developmental Disabilities · Working with Adolescents · BH Services: What are BH Services, Who provides them, and How Do We Work Collaboratively?
Understanding Community Partner Supports	· Scope of services · Partnership and Collaboration with ACOs/MCOs · Comprehensive Assessment and Treatment Plan · Flexible Service: Resources, referral, follow-up · Collaboration and Communication with community agencies
Cultural Perspectives – Recognizing sensitivities to different cultures, religions, values, and backgrounds	· The Impact of Culture on health and health care (with focus on SMI/SUD) · Health Disparities · Culturally Competent Behavioral Health Care Delivery · The LGBTQ Community · CLAS (Culturally, Linguistically, Appropriate Care) Model
Treatment Intervention Approaches	· Engagement & Outreach · Wellness Coaching · Tobacco Cessation · Motivational Interviewing · Harm Reduction Approach · Trauma-Informed Approach

We will partner with ACOs and MCOs to hold periodic conferences for Enrollees, staff, advocates, BH CPs, social service and community agencies to which Subject Matter Experts (including experts from the ACOs, MCOs, and ILCs). We will facilitate staff training by making work hours available for staff to participate on a mandatory basis; tracking participation; enabling online evaluations and scoring; and, providing resource guides and training materials to

reinforce learning. We will also work with ACOs and MCOs to develop and deliver training on topics of mutual and common interest, such as care coordination strategies, community collaboration, and cultural competence.

We will leverage existing MassHealth training and resources into staff training and material, encourage MassHealth training forum attendance and ensure staff interacting with Enrollees with BH needs complete required training on BH competencies.

6. Staff Retention Strategy

As referenced above, there are systemic challenges and barriers to recruiting and retaining qualified, trained and experienced staff. We will address these challenges with a long-range, comprehensive, multi-pronged strategy, including ongoing career development, educational assistance, ongoing on-going licensing and credentialing opportunities, and leadership training.

In the short term, we hope to use DSRIP funds for certain defined workforce development initiatives, including staff retention efforts. We propose collaborating with other BH CPs, ACOs and MCOs to explore opportunities for collaborative efforts to develop and implement staff retention programs, including professional development. Potential areas of focus include:

- Strategies to encourage workforce to continue to earn degrees in higher education and professional credentials
- Provide leadership training and management skills development training to support staff who seek to advance in their careers
- Provide on-going opportunities for continuing education for licensing and credentialing

Funding for these efforts are concentrated in the latter budget years to promote experienced staff staying with our program. We recognize that being able to raise salary levels and benefits is important to promote staff retention; we include a 2% raise each contract year for staff. There are additional non-financial benefits that can also aid in retention by improving staff experience in the workplace. These include:

- Foster an enhanced sense of ownership and accountability among staff by expanding our existing mechanisms to solicit, obtain, and incorporate (to the extent appropriate) staff input into program development, administration, and management
- Cultivate a supportive organizational culture by providing more focused and personalized management, supervision, and mentoring
- Create job opportunities for people in recovery from SUD within the BH CP
- Exploring opportunities to reduce the administrative burden on staff by streamlining recordkeeping and other documentation requirements
- Staff recognition and staff events

Exploring and implementing creative work allocation and scheduling to allow staff to achieve a healthy work-life balance.

F. Implementation Plan and Timeline

We provide implementation timelines for the Preparation Budget Period and each subsequent Budget Period in Attachment 7.3.F.

G. Budget Report and Budget Narrative

We provide our Budget Report and Budget Narrative in Attachments 7.3.G-1 and 7.3.G-2 respectively.

H. Sustainability

The Greater Lowell BH CP will sustainably fund the proposed infrastructure, capacity building investments and BH CP support services during the Contract Term and follow the initial Contract Term through:

- DSRIP Dollars (initial investment and ongoing funds distribution associated with volume
- Shared savings initiatives developed over time with the ACOs/MCOs
- The ability to sell services to MCOs for non-CP eligible individuals who can benefit from CP services to manage the Total Cost of Care for more Enrollees
- Managing fixed costs associated with IT, licensing, fees and general expenditures over time
- Identifying and developing new services for ACO, MCO, and other enrolled individuals to help individuals live independently in the community, decreasing the total cost of care associated with avoidable hospital utilization.

I. Quality Management and Performance Monitoring

1. Quality Management and Improvement Program

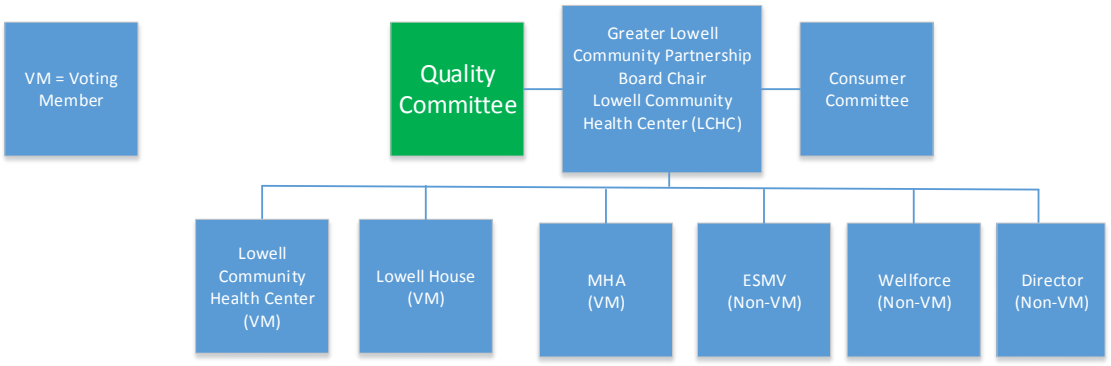
Lowell Community Health Center, Mental Health Association of Greater Lowell and Lowell House each bring to our Partnership a solid commitment and robust processes to measure, review and improve quality of care for our members and communities. Quality is not a department; it is fundamental to the missions and cultures of our organizations and embedded throughout all standardized processes for the BH Community Partnership. The Greater Lowell BH Community Partnership leverages these strengths to assure that we consistently apply evidence-based quality assurance and quality improvement strategies, and that we respond rapidly to program deficits and to identify and disseminate best practices. Our combined quality management/ quality improvement plan emphasizes performance monitoring and improvements to meet the needs of our members, including care coordination, transitions support, clinical quality, member engagement, continuity and a positive and caregiver member experience. We will continue to measure and meet the needs of our communities as well, as defined by the missions of each organization.

We will work to improve care continuously by using data to identify and address anomalies in care and outcomes; developing interventions to ensure that goals are achieved; completing objective measurement processes; and implementing improvement initiatives.

Quality Committee for Shared Accountability

Central to the shared accountability for quality within the Greater Lowell BH CP, is the multi-agency, multi-disciplinary quality committee. The committee will include Quality Managers and Clinical representatives from all three organizations, in addition to the BH CP Program Director and the Data Analyst. The Committee is charged with monitoring performance and driving improvements for the Partnership. The Quality Committee will meet quarterly and as needed to monitor performance and address new or ongoing issues.

The Quality Committee will report to the Governing Board, as shown in the organizational chart below:



Specific responsibilities of the Quality Committee include monitoring data, defining priorities and overseeing improvement projects across the Greater Lowell BH Community Partnership and participating organizations.

Process for Quality Assurance and Quality Improvement

The Quality Committee provides oversight over all quality measurement, prioritization and implementation of quality improvement efforts to assure consistency and shared accountability across the organizations in the Greater Lowell BH Community Partnership.

Review Data on Performance Metrics: The Quality Committee will review data on our performance and benchmarks for all BH Community Partners quality metrics as provided by MassHealth and our MCO/ ACO partners. Additionally, we will review data from other sources, including internal data sources, the Community Needs Survey, and the MassHealth Enrollee Satisfaction Survey, and other sources to establish priorities for improvement or initiatives to meet the needs of our members and communities. The Quality Committee, along with BH Community Partnership leadership, will also discuss any complaints, concerns raised by members or other stakeholders regarding the quality of care delivered and formulate a response plan.

> **Dashboard:** As a part of the data review process, the Greater Lowell BH Community Partnership team will create a dashboard for easy monitoring of priority metrics across organizations and by the Governing Committee and the Consumer Advisory Board. The dashboard will focus on a limited number of priority metrics and will identify current performance of the Partnership, benchmark data if available, identified targets and whether current performance is meeting targets (red, yellow, green markings).

Identify Opportunities for Improvement: Given performance data and needs, the Quality Committee will define a limited number of priorities for focused improvement efforts to improve clinical quality, member engagement, care coordination, continuity and member experience. The Committee will identify priorities through consensus, taking into consideration weighting of quality metrics in the accountability score, the priorities of partner ACOs including utilization and contributors to total cost of care, ongoing improvement efforts by Partnership

agencies, and community needs. The Committee will select at least one main priority for improvement from the quality metrics each quarter.

Strategies to Improve Performance: The Quality Committee will launch or oversee concrete performance improvement initiatives, driven by the principles of continuous quality improvement and plan-do-study-act, to respond to priority improvement initiatives. The Committee will initiate a deep-dive into data or processes to identify root causes or variation in processes, as well as any best practices among organizations in the Partnership. Data sources could include: medical record review, Enrollee and/or provider complaints, utilization review, and survey data.

Each organization within the Partnership will champion performance improvement projects within their own organization, in line with the priorities and findings of the Quality Committee and best practices. In this way, the Greater Lowell BH Community Partnership assures the shared accountability for performance across agencies and supports the sustainability of performance improvement programs. Each organization will include their front-line and leadership staff to plan and implement improvement efforts. Representatives from each organization will report back on findings of the improvement initiatives at each Quality Committee quarterly meeting.

If the improvement program targets standardized processes across the Partnership, the planning and implementation team will include shared staff and representatives from each organization to refine the common practices and reduce variation.

Quality Management/ Quality Improvement (QM/QI) Plan

In line with the Quality Management infrastructure and processes outlined above, the Greater Lowell BH Community Partnership Quality Committee will develop an Annual Quality Management Plan as required in our contract with MassHealth. The Quality Management Plan includes the dashboard of current performance, the specific goals for improvement and the summary of actions anticipated in the coming year to address challenges in member engagement, clinical quality or member experience. Specifically, the plan will include at least three quality improvement projects throughout the year focusing on some or all the priority domains:

- Member quality of life;
- Chronic disease management;
- Caregiver stress;
- Community tenure, isolation and social connectedness;
- Care coordination or care management; or
- Care transitions.

The QM/QI Plan will be a responsive, dynamic document and we will continually update it based on stakeholder input, data analysis, Quality Committee priorities and subsequent performance metrics reporting.

2. Sample Quality Initiative

Greater Lowell BH CP is committed to improving care for our Members by enhancing the quality of services we provide. To that end, we propose to implement a quality initiative related to enhancing Care Coordination and Care Management for high-cost, high-risk Enrollees served by the MassHealth program.

Description: In Year 1, engaging our attributed and assigned members in high quality care coordination services is our top priority. As with any new program, we anticipate that engaging members to complete a comprehensive assessment and develop a care plan within 90 days of assignment will be challenging. We expect barriers to engaging members already working with our agencies and members not known to us, although those challenges may be different. Initial engagement is important to assure that our members receive the care coordination, case management and additional benefits that will help them maintain health and quality of life and promote effective, efficient care.

Through our quality management program in year 1, we will implement close data monitoring and a Plan-Do-Study-Act approach, including these steps:

- Hire and train dedicated Engagement Specialist to provide initial outreach attempts to members and support with scheduling comprehensive assessments;
- Develop a dedicated dashboard to review progress toward engaging members within 90 days;
- Establish common outreach processes and procedures based on evidence-based, best practices to include phone calls at letters, in person outreach strategies;
- Connect with community based organization around the Greater Lowell region where our members may access services, including ways in which we can partner to engage members;
- Develop common templates and strategies for initial member engagement communications;
- Process for consistent monitoring of each outreach strategy to determine effectiveness at reaching members and obtaining agreement to participate in the assessment and the case management program;
- Initiate Quality Committee meetings to review data including drill-down data, discuss any patterns of success or failures in member engagement and define improvement strategies;
- Measure success at engaging members as defined by the metrics below.

Domains: Member engagement in the BH Community Partnership program is fundamental to achieving all priority areas, especially care coordination and case management.

Target Population: The target population for this initiative includes all members who are attributed or assigned to the Greater Lowell BH Community Partnership in year 1.

Measures for Success: Measures of success and targets for this effort are aligned with the member engagement quality metrics for the BH Community Partner program:

Measure	Population (Known to BH CP or Unknown)	Target
Percentage of CP Assigned Enrollees with documentation of a comprehensive assessment and approval of a care plan by primary care clinician or designee and member (or legal authorized representative, as appropriate) within 90 days of assignment to BH CP	Members known Partnership Organization(s)	75%
Percentage of CP Assigned Enrollees with documentation of a comprehensive assessment and approval of a care plan by primary care clinician or designee and member (or legal authorized representative, as appropriate) within 90 days of assignment to BH CP	Members not known to Partnership Organization(s)	60%

We will add additional, interim metrics as needed to monitor the performance of each organization and the Partnership overall in engaging members.

We will implement this initiative in Budget Period 1 and continuously evaluate the effectiveness of this initiative in meeting established goals. Data related to this initiative will be continuously monitored through our Quality Committee structure as described above.

J. Coordination with ACOs and MCOs

1. Strategies to Communicate Skills, Expertise, and Value to ACOs and MCOs

Greater Lowell BH CP is aware that an essential part of the success of the BH CP contract relies on our shared ability to coordinate key elements of our BH CP infrastructure with ACOs and MCOs in our service area. We believe that Enrollees will be best served by the ACO or MCO sharing a single, modular Comprehensive Assessment and ICP Plan that supports the sharing of complete, up-to-date integrated Enrollee information across organizations, including state agencies and community-based organizations. Such sharing of information is crucial to the

delivery of integrated care management and represents an opportunity to achieve savings on infrastructure and IT resources.

From the outset, we will a have a compliant, functioning solution that supports care integration; however, over time, our desire is to have a fully interoperable system capable of supporting shared assessments, care plans, reporting and quality management functions. We believe that creating a fully integrated IT system is the State's responsibility; however, we are already collaborating with ACO and MCO partners in our service area and will do everything possible to support such collaboration.

We have already initiated discussions with ACOs and MCOs in our service area to discuss our skills, expertise, and value to care integration efforts. Such discussions will continue over the next several months as BH CP, LTSS CP, ACO and MCO contracts are awarded by EOHHS. We are communicating and will continue to educate ACOs and MCOs regarding:

- Shared responsibility in caring for MassHealth consumers with the greatest needs and level of risk, given their SMI and/or SUD diagnosis.
- The contribution that the Greater Lowell BH CP can make to delivering quality care for individuals with SMI and SUD diagnoses. We will impact integration, patient satisfaction and Total Cost of Care (TCOC) among other measures, all of which will be vitally important to our Enrollees and to our organization, ACOS and MCOs our joint efforts to deliver care
- The breadth and depth of BH CP services available to Enrollees who are eligible for such services. For example, we will discuss the specialized nature of the BH CP component of the Comprehensive Assessment, the Individualized Care Plan (ICP) and ongoing care plan implementation and monitoring.
- The importance of primary care delivery for individuals with SMI and SUD, many of whom go without primary care services for a variety of reasons. One of our goals is to ensure that individuals with significant BH diagnoses receive primary care services, given that individuals with SMI diagnoses die, on average, 25 years earlier than their peers without an SMI diagnosis.
- Collaborative strategies to integrate primary care and BH care for BH CP eligible individuals in the assessment, care planning, and care delivery process.

2. Branding and Marketing Plans the Bidder Has Regarding Its Relationship with ACOs and MCOs

Greater Lowell BH CP will develop educational materials for Enrollees that inform them of our BH CP services, guided by MassHealth policy and procedure, which clearly prohibits MassHealth vendors from directly marketing to Enrollees. Our priority will be to serve Assigned Enrollees who have a pre-existing relationship with our organization.

For Marketing and Branding, we plan to take a highly educational approach including, but not limited to:

- Developing a consumer awareness campaign of the value of BH CP services for individuals with significant BH needs. Our goal is to enhance access through such awareness. Materials will be made available to ACOs and MCOs in the most commonly spoken languages in the service area and can be distributed to Enrollees as part of the Enrollment process.
- Use the local media outlets, including Lowell Telecommunications, radio stations and our relationship with the Lowell Sun, to assure we reach all potential Enrollees in the Greater Lowell area.
- Educating ACO and MCO partners regarding our services, our approach to Enrollee services and the nature of integration we offer, which will benefit Enrollees.

3. Collaboration with Multiple ACOs in the Service Area

The Greater Lowell BH CP will provide information and reach out to develop relationships with all ACO and MCO partners in the Service Areas for which this bid applies.

4. Conflict Resolution

The Greater Lowell BH CP will partner closely with ACOs and MCOs in the Service Area to serve the needs of BH CP eligible individuals. We will leverage and build upon the strengths that our organization and our partner organizations bring to this engagement. While we do not anticipate disagreements in areas of shared responsibility, we recognize that differences of opinion may arise, specifically related to care management decisions that affect Enrollees or the way the Contract is managed. Our mutual intention is to resolve those disagreements promptly, so there is no harm whatsoever to Enrollees and maintains compliance with the terms of the Contract.

In general, the forum for resolving disagreements and conflicts between the BH CP and the ACO or MCO will be addressed at the Board of Directors. Going forward, we will create a structured process to escalate issues of significant financial impact to the ACO or MCO, or other major strategic issues. Delivering effective outreach and engagement activities to active drug users is challenging and requires significant shifts in approach for many providers. To be effective, several key features of the population must first be understood; including stigma, trauma, disengagement, a disease of SUD and lack of available resources. Barriers and factors to consider when outreaching to this population in a traditional way include legal issues, homelessness, lack of transportation, family disengagement, lack of social supports, co-occurring mental and physical health issues.

Community Partner Program Budget Report

				Riverside Community Care				
	Program Revenue	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
	Estimated Enrollees- Start of Period (All Enrollees)		1,480	1,800	2,500	3,100	3,500	
	Estimated Enrollees - End of Period (All Enrollees)		1,800	2,500	3,100	3,500	3,800	
	Estimated Enrollees - Monthly Average (excl CBFS enrollees)		1,566	1,966	2,567	3,072	3,431	
	Estimated Enrollees - Monthly Average (CBFS enrollees only)		39	135	200	200	200	
	Estimated Program Revenue (excl CBFS enrollees)		$ 1,972,800	$ 4,246,812	$ 5,544,648	$ 6,634,800	$ 7,410,852	$ 25,809,912
	Estimated Program Revenue (CBFS enrollees only)		$ 67,500	$ 405,000	$ 600,000	$ 600,000	$ 600,000	$ 2,272,500
	Total Estimated Program Revenue		**$ 2,040,300**	**$ 4,651,812**	**$ 6,144,648**	**$ 7,234,800**	**$ 8,010,852**	**$ 28,082,412**
	At- Risk Withhold Rate			0%	0%	0%	0%	
	Withhold funds			$ -	$ -	$ -	$ -	$ -
	Revenue for Operations		**$ 2,040,300**	**$ 4,651,812**	**$ 6,144,648**	**$ 7,234,800**	**$ 8,010,852**	**$ 28,082,412**
	Program Expenses	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
1	**Salary**	$ 196,465	$ 1,465,433	$ 3,594,374	$ 4,590,000	$ 5,338,336	$ 5,968,788	$ 21,153,394
2	**Fringe**	$ 41,179	$ 307,155	$ 753,381	$ 962,064	$ 1,118,915	$ 1,251,058	$ 4,433,751
	Total Personnel Costs	$ 237,644	$ 1,772,587	$ 4,347,754	$ 5,552,064	$ 6,457,251	$ 7,219,846	$ 25,587,146
3	**Training & Professional Development**	$ -	$ 10,815	$ 26,140	$ 32,895	$ 37,701	$ 41,540	$ 149,091
4	**Travel**	$ -	$ 45,964	$ 111,097	$ 139,804	$ 160,229	$ 176,543	$ 633,637
5	**Equipment**	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	**Supplies**	$ -	$ 48,384	$ 116,946	$ 147,164	$ 168,665	$ 185,838	$ 666,996
7	**Contract Services** (consulting, professional)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	**Software licensing**	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	**Telecommunications**	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	**Occupancy** (rent, utilities, maintenance)	$ -	$ 202,781	$ 490,133	$ 616,783	$ 706,894	$ 778,867	$ 2,795,458
11	**Other**	$ 88,250	$ 252,019	$ 423,182	$ 446,237	$ 465,938	$ 484,133	$ 2,159,760
	Total Direct Costs	$ 325,894	$ 2,332,550	$ 5,515,252	$ 6,934,947	$ 7,996,678	$ 8,886,767	$ 31,992,089
12	**Indirect Cost/Administrative Overhead** 10.7%	**$ 34,968**	**$ 250,283**	**$ 591,787**	**$ 744,120**	**$ 858,044**	**$ 953,550**	$ 3,432,751
	TOTAL EXPENSES	$ 360,862	$ 2,582,832	$ 6,107,039	$ 7,679,067	$ 8,854,722	$ 9,840,317	$ 35,424,840
	Surplus/Shortfall	*$ (360,862)*	*$ (542,532)*	*$ (1,455,227)*	*$ (1,534,419)*	*$ (1,619,922)*	*$ (1,829,465)*	*$ (7,342,428)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	100% salary cost	Total (91.1757% **)
Clinician Care Manager	$ 65,000	4.500	2.5	$60,938	$ 55,560
Care Coordinator	$ 40,000	29.600	1.0	$98,6667	$ 89,960
Nurse Care Manager	$ 75,000	3.700	1.2	$27,508.3	$ 25,081
LPN	$ 60,000	3.700	1.0	$18,500.0	$ 16,868
Psychiatry	$ 240,000	0.093	0.0		$ -
Program Manager	$ 80,000	0.740	2.0	$9866.7	$ 8,996
					$ -
					$ -
					$ -
Total Salary (Program Budget Line 1)		**42.3325**		**$215,479.177**	**$ 196,465**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 196,465	21%	$ 41,179
Total Fringe (Program Budget Line 2)			**$ 41,179**

Total Personnel*	**$ 237,644**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities: The above positions represent the Care Coordination Team staffing that we plan to have in place across our BH CP by the start of Year 1 (4.5 teams to start, eventually staffing up to 9.5 teams by end of Year 5).

Each team will consist of the following:

1) A Clinical Care Manager/Team Leader manages each locally-based team (1 per team).
2) Care Coordinators for each team will provide most of the direct care coordination services for the program (8 per team)
3 & 4) An RN and an LPN will ensure the medical needs of the people we serve are met on a day-to-day basis. The RN on each team will supervise the LPN. (1 Rn and 1 LPN per team)
5) A Psychiatrist serves as the Medical Director for each team (2.5% of an FTE per team)
6) A Program Manager who is the independent licensed clinician responsible for the day-to-day operations (20% of an FTE per team)

Each Affiliated Partner may adjust the model of their team(s), including salaries, to align with their own organization's compensation plan, but will meet all contractual obligations.

At the end of the Prep Budget Period the Care Coordination team staff FTEs in place will be as follows:
1) 4.5 Clinical Care Managers
2) 29.6 Care Coordinators
3&4) 3.7 RNs and 3.7 LPNs
5) No psychiatry
6) .74 Program Managers

**** Note: Our true Prep Budget Period start-up staffing cost is expected to be ~$25k more than the $450k DSRIP funding. In order to cap our expenses at $450k, we've reduced our program budget spending on each staff member above to 91.1757% of what we expect to spend. In other words, Riverside and it's AP's are expecting to fund approximately 8.243% of the above start-up staff costs with DSRIP funds in the Prep Period.**

Row 3 - Training and Professional Development

	A	B	C	D	E	F	G
53	**Description of Service**	**Unit Cost (if applicable)**	**# Staff (if applicable)**	**Total Cost**			
54							
55							
56							
57	**Total Training and Professional Development**						
58	**(Program Budget Line 3)**			**$ -**			
59							
60	***Provide a description of each Training and Professional Development line item included in the table above:***						
61							
62							
63							
64							
65	**Row 4 - Travel**						
66	**Position**	**Est miles per month**	**# months**	**Mileage reimbursement rate**		**Total Cost**	
67						$ -	
68						$ -	
69						$ -	
70						$ -	
71						$ -	
72						$ -	
73				**Total Mileage**			
74							
75	**Travel Expense Description**	**Cost**					
76	Total Mileage	$ -					
77	Parking and tolls						
78	Public transportation						
79	Enrollee travel						
80	**Total Travel**						
81	**(Program Budget Line 4)**	**$ -**					
82							
83	***Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel***						
84	***expenses above, please explain how these expenses will be used by enrollees.***						
85							
86							
87							
88							
89	**Row 5 - Equipment**						
90	**Description of Equipment**	**Unit Cost or Cost/FTE**	**#units or FTEs**	**Cost**			
91							
92							
93							
94							
95							
96							
97							
98	**Total Equipment (Program Budget Line 5)**			**$ -**			
99							
100	***Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were***						
101	***determined:***						
102							

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Total Supplies (Program Budget Line 6)			**$ -**

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			**$ -**

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
Total Software Licensing (Program Budget Line 8)			**$ -**

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Total Telecommunications (Program Budget Line 9)			**$ -**

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent			$ -
Utilities			$ -
Repair and Maintenance			$ -
			$ -
			$ -
Total Occupancy (Program Budget Line 10)			**$ -**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

Row 11 - Other

Other Direct Expense Description	Cost
Sr. Mgr - 0.375 FTE @ $110k for 6 mo	$ 20,625
Prog Mgr - 0.8 FTE @ $80k for 6 mo	$ 32,000
Admin - 2.0 FTE @ $42k for 2 mo each	$ 14,000
Quality Mgr - 0.2 FTE @ $95k for 4 mo	$ 6,333
Fringe (20.96%)	$ 15,292
Total Other (Program Budget Line 11)	**$ 88,250**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined: Our structure relies on Riverside BH CP management staff to support the overall program. Costs in this line include salary and fringe associated with these staff. By the end of the prep budget period, the BH CP management staff will include the following:

1) A senior licensed clinician manager that is a member of Riverside's Leadership Team supervises the Program Director of the

Riverside BH CP in their capacity as both Program Director and Program Manager of the Riverside Care Coordination Team(s).
2) A program director is dedicated to the program. They are responsible for the day to day operation of Riverside BH CP, including oversight of our Affiliated Partners.
3) 2 administrative support positions will work solely for the program; A) a contract administrator will focus on contract management and monitoring, preparing claims and invoices, reports, and related information and submissions, B) a administrative assistant will serve as the coordinator of meetings, projects, and provide general support.
4) A quality manager who will also will be a member of Riverside's Quality Management Department will provide the quality management for the BH CP.

Note: Beginning in BP1, .5FTE of a senior manager who is a member of Riverside's Leadership Team is responsible for program development will be a part of the "Other" expenses.

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	**10.73%**	**$ 34,968**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined: The rate is Riverside's FY18 budgeted general and administrative overhead/indirect cost rate applied consistently across all Riverside programs.

Community Partner Infrastructure Budget Report

		Riverside Community Care						
	Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
	PMPM Infrastructure Rate		$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
	Engaged Enrollees		1,800	1,800	2,500	3,100	3,500	
	Estimated Infrastructure Funds		$ 1,260,000	$ 1,858,680	$ 1,544,947	$ 1,688,880	$ 1,649,949	**$ 8,002,456**
	At- Risk Withhold Rate			25%	44%	63%	81%	
	Withhold			$ 464,670	$ 679,777	$ 1,063,994	$ 1,336,458	**$ 3,544,899**
	TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 1,260,000	$ 1,394,010	$ 865,170	$ 624,886	$ 313,490	**$ 4,907,556**
	Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
	Technology							
1	**IT Staffing including Fringe**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
2	**Development Adaptation of EHR and/or Care Management System**	$ 55,000	$ -	$ -	$ -	$ -	$ -	**$ 55,000**
3	**Technology for Service Delivery**	$ 25,500	$ 87,000	$ 37,500	$ -	$ -	$ -	**$ 150,000**
4	**Other Technology Expenses**	$ -	$ 150,000	$ 17,500	$ 30,000	$ 30,000	$ 30,000	**$ 257,500**
	Total Technology	$ 80,500	$ 237,000	$ 55,000	$ 30,000	$ 30,000	$ 30,000	**$ 462,500**
	Workforce Development							
5	**Workforce Development staffing including Fringe**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
6	**Recruitment Expenses**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
7	**Training Expenses**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
8	**Retention Expenses**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Workforce Development	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Business Start Up Costs							
9	**Office Equipment (PBP & BP1 only)**	$ -	$ 42,500					**$ 42,500**
10	**Office Furniture (PBP & BP1 only)**	$ -	$ 80,000					**$ 80,000**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**	$ 360,862	$ 542,532	$ 1,455,227	$ 1,534,419			**$ 3,893,041**
	Total Business Start Up Costs	$ 360,862	$ 665,032	$ 1,455,227	$ 1,534,419	$ -	$ -	**$ 4,015,541**
	Operational Infrastructure							
12	**Operation Staffing including Fringe**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
13	**Other Operational Expenses**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Operational Infrastructure	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
14	**Indirect Cost/Administrative Overhead Rate** 10.7%	$ 8,638	$ 38,574	$ 5,902	$ 3,219	$ 3,219	$ 3,219	**$ 62,771**
	TOTAL INVESTMENTS	**$ 450,000**	**$ 940,607**	**$ 1,516,129**	**$ 1,567,638**	**$ 33,219**	**$ 33,219**	**$ 4,540,812**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary			$ -
	Fringe rate	21.0%	Total Fringe	$ -
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
IT Consultant	$ 55,000
Total Development and Adaptation of EHR and Care Management System (Infrastructure Budget Line 2)	**$ 55,000**

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined: We intend to contract for IT services to support initial start-up so that each participating organization has a resource to ensure they are able to operate on the go-live date. This contracted resource will be overseen by Riverside's Chief Information Officer. At a minimum, the IT contracted service will ensure that each organization is able to provide required information to Riverside for management and billing purposes, and also provide support for care management. We have budgeted 275 hours at $200 per hour.

Please note that Riverside has available software to support our own care management activities and to support Affiliated Partners that wish to use our Netsmart product. There is a nominal cost for expanded used of the product for those AP's that choose to utilize it.

Row 3 - Technology for Service Delivery

Description of Expense	Cost
Laptops	$ 25,500
Total Technology for Service Delivery (Infrastructure Budget Line 3)	**$ 25,500**

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined: Laptops will be distributed across Riverside Affiliated Partners in this category. Each Affiliated Partner is able to choose the equipment in this category that best meets their needs in meeting the requirements described in the RFR. This equipment will be primarily laptops with the capacity for electronic signatures by enrollees. Riverside's current pricing for Dell laptops that have a touch screen, microphones, cameras, speakers, and eSig software is $1,500 each. Prior to launch, we expect to purchase 17 laptops, with more purchased in future years. The allocation of the $25,500 for equipment for our Riverside teams and to our APs for theirs is as follows: $6,924 for Riverside teams, $5,944 for North Suffolk and $5,944 for Lynn, $2,972 for Edinburg, $1,486 for Dimock and $1,486 for Uphams and $743 for Brookline.

6,924	Riverside
5,944	North Suffo
5,944	Lynn
2,972	Edinburg
1,486	Dimock
1,486	Uphams
743	Brookline
25,500	

Row 4 - Other Technology Expenses

	A	B	C	D	E	F	G
69	**Description of Expense**	**Cost**					
70							
71							
72							
73							
74							
75							
76	**Total Other Technology Expenses**						
77	**(Infrastructure Budget Line 4)**	**$** -					
78							
79	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and***						
80	***how the costs were determined:***						
81							
82							
83							
84	**Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period**						
85							
86	**Row 5 - Workforce Development Staffing including Fringe**						
87	**Position**	**Annual Salary**	**FTEs**	**# Months**	**Total**		
88					$ -		
89					$ -		
90					$ -		
91					$ -		
92					$ -		
93					$ -		
94					$ -		
95					$ -		
96					$ -		
97		Total Salary	0		$ -		
98		Fringe rate	21.0%	Total Fringe	$ -		
99				**Total Workforce Development Staffing including Fringe**			
100				**(Infrastructure Budget Line 5)**	**$** -		
101							
102	***For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of***						

the CP's contract:

Row 6 - Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ -**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Row 7 - Training Expenses

Description of Expense	Cost
Total Training Expenses (Infrastructure Budget Line 7)	**$ -**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Row 8 - Retention Expenses

Description of Expense	Cost
Total Retention Expenses (Infrastructure Budget Line 8)	**$ -**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Business Start Up Costs - Prep Budget Period

Row 9 - Office Equipment

Description of Expense	Cost
Total Office Equipment (Infrastructure Budget Line 9)	**$ -**

Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were determined:

Row 10 - Office Furniture

Description of Expense	Cost
Total Office Furniture (Infrastructure Budget Line 10)	**$ -**

Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -

	A	B	C	D	E	F	G
203		Total Salary	0		$ -		
204		Fringe rate	21.0%	Total Fringe	$ -		
205	**Total Program Staffing including Fringe**				**$ -**		
206	**(Infrastructure Budget Line 12)**						
207							
208	***For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of***						
209	***the CP's contract:***						
210							
211							
212							
213	**Row 13 - Other Operational Expenses**						
214	Description of Expense		Cost				
215							
216							
217							
218							
219							
220							
221	**Total Other Operational Expenses**		**$ -**				
222	**(Infrastructure Budget Line 13)**						
223							
224	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's***						
225	***contract and how the costs were determined:***						
226							
227							
228							
229	**Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period**						
230							
231	**Row 14 - Indirect Cost/Administrative Overhead**						
232	**Indirect Cost/Administrative Overhead**		**Rate**		**Total Indirect Cost**		
233	**Total Indirect Cost/Administrative Overhead**		**10.73%**		**$ 8,638**		

	A	B	C	D	E	F	G
234	**(Program Budget Line 14)**	10.75%	$	8,638			
235							
236							
237	***Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:*** The rate is						
238	Riverside's FY18 budgeted general and administrative overhead/indirect cost rate applied consistently across all Riverside programs.						
239							
240							
241							

Community Partner Infrastructure Allocation Worksheet

	Riverside Community Care						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 1,260,000	$ 1,394,010	$ 865,170	$ 624,886	$ 313,490	$ 4,907,556
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Riverside	$ 70,561	$ 199,052	$ 33,583	$ 33,219	$ 33,219	$ 33,219	$ 402,853
North Suffolk	$ 5,944	$ 20,281	$ 8,742	$ -	$ -	$ -	$ 34,967
Lynn	$ 5,944	$ 20,281	$ 8,742	$ -	$ -	$ -	$ 34,967
Edinburg	$ 2,972	$ 10,141	$ 4,371	$ -	$ -	$ -	$ 17,484
Dimock	$ 1,486	$ 5,070	$ 2,185	$ -	$ -	$ -	$ 8,742
Uphams	$ 1,486	$ 5,070	$ 2,185	$ -	$ -	$ -	$ 8,742
Brookline	$ 743	$ 2,535	$ 1,093	$ -	$ -	$ -	$ 4,371
Total Technology	$ 89,138	$ 262,430	$ 60,902	$ 33,219	$ 33,219	$ 33,219	$ 512,126
Workforce Development							
Riverside	$ -	$ -	$ -	$ -	$ -	$ -	$ -
North Suffolk	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lynn	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Edinburg	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dimock	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Uphams	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Brookline	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs							
Riverside	$ 187,742	$ 400,828	$ 770,418	$ 797,316	$ -	$ -	$ 2,156,304
North Suffolk	$ 55,398	$ 88,752	$ 219,139	$ 228,612	$ -	$ -	$ 591,901
Lynn	$ 55,398	$ 88,752	$ 219,139	$ 228,612	$ -	$ -	$ 591,901
Edinburg	$ 27,699	$ 44,376	$ 109,569	$ 114,306	$ -	$ -	$ 295,950
Dimock	$ 13,850	$ 22,188	$ 54,785	$ 57,153	$ -	$ -	$ 147,975
Uphams	$ 13,850	$ 22,188	$ 54,785	$ 57,153	$ -	$ -	$ 147,975
Brookline	$ 6,925	$ 11,094	$ 27,392	$ 28,576	$ -	$ -	$ 73,988
Business Start Up Costs	$ 360,862	$ 678,177	$ 1,455,227	$ 1,511,728	$ -	$ -	$ 4,005,994
Operational Infrastructure							
Riverside	$ -	$ -	$ -	$ -	$ -	$ -	$ -
North Suffolk	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lynn	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Edinburg	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dimock	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Uphams	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Brookline	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL INVESTMENTS	$ 450,000	$ 940,607	$ 1,516,129	$ 1,544,947	$ 33,219	$ 33,219	$ 4,518,120

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Development and Adaptation of E.H.R/Care Management System	Selected/modified/and implemented initial Care Management Software	11/01/17	05/01/18	We will have a consultant and/or employee working on this project	Responsible person in place/working						
Technology												
Technology												
Technology												
Workforce Development												
Workforce Development												
Workforce Development												
Workforce Development												
Business Start Up Costs	Program Staffing including Fringe	Recruit, hire and train selected core team members	01/01/18	05/31/18	Recruitment ongoing and offers made to select clinical team members	Select clinical team member hired and prepared to start enrolling MassHealth members.						
Business Start Up Costs												
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure												
Operational Infrastructure												
Operational Infrastructure												
Operational Infrastructure												

BH Community Partner - Staffing Model

Riverside Community Care

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	1,800	*Should align with Program Budget RIVERSIDE: Based on 4.5 Care Coordination Teams in Year 1*

	BH CP Program Staff	Budget Period 1 FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	2.1	*Total management oversight of BH CP RIVERSIDE: Includes 0.375 Sr Manager, 0.8 Program Director, 0.2 Program Managers per team*
3	Medical Director	0.1	*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1 RIVERSIDE: Includes 0.025 Phychiatrists per team*
4	RNs	4.5	*RIVERSIDE: Includes 1.0 RN per team*
5	Clinical Care Managers (RN)	0.0	*Do not include FTEs listed in line 4*
6	Clinical Care Managers (LPHA)	4.5	*LPHA includes LICSW, LMHA, LADC I RIVERSIDE: Includes 1.0 Clinician Care Manager per team who in most cases will serve as team leader*
7	Supervisors/Team Leaders	0.0	*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff	4.5	*Do not include FTEs listed in lines 4, 5, 6 or 7 RIVERSIDE: Includes 1.0 LPN per team*
9	Care Coordinators	36.0	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination) RIVERSIDE: Includes 8.0 Care Coordinators per team*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)	0.0	*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists	0.0	
12	Administrative Support	2.7	*RIVERSIDE: Includes Management Costs: (0.2 Quality Managers, 0.5 Program Development Sr. Managers), and 2.0 Admin support*
13			
14	Total FTE	54.4	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1:400	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers) RIVERSIDE: In addition to the 1 RN per team, each team of 400 will also have an LPN supervised by the RN and through several of our APs the Riverside BHCP teams will have access to additional RNs in the organizations, which will also supplement the designated RNs.*
16	Care Coordinator Supervision to Care Coordinators	1:8	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff: The Clinical Care Managers directly supervise the Care Coordinator staff.

BEHAVIORAL HEALTH COMMUNITY PARTNERS RFR
RFR Document #: 17EHSBHCPRFR
BID#: BD-17-1039-EHS01-ESH01-11588

Riverside Community Care, Inc.

PROGRAMMATIC RESPONSE
Preliminary DSRIP Participation Plan (Section 7.3)
(Revised per instruction, 12-5-17)

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Section 7.3 Initial DSRIP Participation Plan

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Section 7.3.A Executive Summary

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Section 7.3 Initial DSRIP Participation Plan

The Bidder's response to this Section 7.3 shall constitute Bidder's Initial DSRIP Participation Plan as described in Section 4.1 of Attachment A.

A. Executive Summary (not to exceed 2 pages). The Bidder shall describe its five year business plan for implementing the CP program. This plan shall include, but is not limited to:

1. The Bidder's goals, identified challenges related to the care delivery system and behavioral health, and proposed solutions to be effectuated through the CP program

Riverside has a decades-long commitment to serving individuals with significant behavioral health needs through our large array of services and through partnering with State Agencies, healthcare systems, cities and towns, social services and other behavioral healthcare providers. Through our experience, we are well aware of the challenges to providing optimal care, to improving the service recipient's experience, avoiding duplication of service, and to optimizing use of healthcare dollars because of insufficient coordination among providers, and especially between behavioral and medical health care systems. We look forward to participating in MassHealth's 1115 demonstration as a BH CP provider to help strengthen the linkages between care providers, support people with high BH needs to better navigate the health and behavioral healthcare systems, attain needed social supports, and ultimately improve their experience and facilitate their personal investment in and achievement of maximum possible healthcare outcomes. We firmly believe that better coordinated care has the potential to help individuals improve their overall health more quickly and fully, prevent avoidable future health problems, reduce use of costly emergency room and inpatient hospitalizations and improve the quality of people's lives. In fact, we have seen these gains demonstrated in our grant based care coordination programs. This opportunity to better serve the individuals and communities who rely on us for behavioral healthcare, expand our reach to more individuals in need, and contribute to the long-term sustainability of the MassHealth system in our state is very welcome.

To accomplish this, Riverside has brought together 6 other organizations to join us in establishing BH CP teams throughout our proposed service areas; we are calling Riverside Community Partners. Our program has a strong platform of mental health and addictions knowledge and experience, healthcare and health behavior promotion know-how, ability to serve a culturally diverse population, and familiarity with social services and supports available in local communities up through state agencies. We intend to leverage this strong base to create centralized BH CP administration and resources with local BH CP teams for service delivery, thereby supporting accessibility, preserving existing local relationships, and ensuring that Enrollees with high behavioral health needs can continue to work with us, providers they have come to trust over many years.

2. The number of Assigned and Engaged Enrollees the Bidder intends to support under the Contract. We propose to support 3,800 Assigned or Engaged Enrollees through our BH CP.

3. The Service Areas for which the Bidder is bidding

Riverside, along with our 6 Affiliated Partners is proposing to serve the following Service Areas:

- In the Greater Boston Region: Boston-Primary; Revere, Somerville, Quincy (all areas)
- In the Northern Region: Lowell, Lynn, Malden, Woburn
- In the Central Region: Framingham, Southbridge, Waltham

4. The Bidder's plans to operationalize the CP program and time frames associated with implementing such activities.

If awarded the contract for the BH CP program, we plan to continue preparatory activities immediately, even prior to the Preparation Budget Period. This will include planning meetings with key personnel already employed at Riverside who will be assuming direct oversight roles in the BH CP program, as well as with leadership of our Affiliated Partners. Nora Kenny-Houser, LICSW, currently Program Director of our Collaborative Care Management Program, will become the Director of Riverside Community Partners, and Jason Moscato, RN, LMHC, a member of Riverside's Senior Management will be her direct supervisor. Riverside's President/CEO, Scott M. Bock, Executive Vice President/COO, Marsha Medalie, and Vice President of Program Development and Strategic Planning, Laurie Hutcheson along with staff from our QM, A&F and HR Departments will also participate. Activities such as developing the formal program policy manual, training curricula, etc. will begin and continue throughout the Preparation Budget Period and into Period 1 (with revisions occurring as needed throughout the five year period and beyond).

During the Preparation Budget Period, we will formally move the Program Director into her new role on December 1, 2017 (as well as begin the dedicated time from our Senior Manager), and begin recruiting and hiring BH CP staff for all the teams. To accomplish this, we created a start-up DSRIP budget that will allow Riverside and each Affiliated Partner to begin hiring Clinical Care Managers/Team Leaders, Care Coordinators and Nurse Care Managers ahead of the program's go-live date. Training of this core staff will begin during this period, with additional training provided as more staff are hired and the program is further developed during subsequent budget periods. We will also identify, rent and set up new offices where needed, and purchase computers, phones, office furniture and other equipment and supplies for teams to be ready to begin operations June 1, 2018. Simultaneously, we will be working on refining the care management software program we intend to use so that it will better meet the specific needs of data management and reporting required for BH CP and developing marketing materials for the program. We will also complete contracting with ACOs/MCOs during this period.

In Period 1, we will continue ramping up staffing across all team as referrals flow in, with many Enrollees being people we already serve, and estimate that we may reach 50% of our capacity. We know actual referral rates may be significantly more or less than this. Therefore, we expect to be flexible in hiring (e.g. adding RNs and LPNs), and also recognize that staff will not operate with full caseloads initially. The Period 1 DSRIP will help offset expenses of operations (staffing) without full revenue. We expect to have substantive discussions with ACOs/MCOs as well as with MassHealth during this period as BH CP is implemented across the state and practices, protocols, best means of communication and relationships across systems become more defined. In Periods 2 through 5 we expect the ramp up of referrals to continue and we assume we will reach 100% of our capacity in year 5. By that time, we will have achieved full caseloads, completed the purchase and set up of all equipment and systems (other than normal replacements or enhancements). (see revised budgets). We expect that the quality of our work will have demonstrated our value to ACOs/MCOs so that they will choose to continue contracting with us beyond the 5 year demonstration period.

Section 7.3.B Supporting Populations and Community Engagement

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Section 7.3 Initial DSRIP Participation Plan

B. Supporting Populations and Community Engagement (not to exceed 2 pages)

1. For each Service Area for which the Bidder is bidding, the Bidder shall describe its connections to the community, including current and planned collaborations and partnerships with community-based organizations, advocacy groups, BH service providers, state agencies, housing/shelter providers, and social service organizations in order to support the focus populations, as described in Section 3.3, and the delivery of CP Supports as described in Section 2.3 of Attachment A.

Throughout the Service Areas noted below, Riverside Community Partners have remarkably long, established relationships with these local communities as well as with local chapters of state-wide organizations such as NAMI and with site offices of State Agencies (DMH, MRC, etc.) through contracts and collaborations over many decades. Other local examples follow below; please note that many cited examples apply to multiple Service Areas but are listed only once due to space limitations:

Boston –Primary- Dimock, Upham's Corner HC, North Suffolk MHA, Riverside, and Brookline CMHC have built strong connections to these communities over many decades. The two health centers are themselves regarded as critical community resources for medical care as well as BH care. Dimock's internal collaborations include Detox Services, housing for adults in recovery and the Mary Eliza Mahoney House emergency shelter. Casa Myrna, Bay Cove, Topeka Street Clinic, Hope House, Entre Familia's Pregnant/Postpartum Project, St. Paul's Food Pantry, Mass. General Hospital, and BI Deaconess Hospital are examples of collaborations.

Revere – North Suffolk is deeply embedded in these communities. Examples of connections include East Boston Neighborhood Health Center, Buddhist temples in Revere and East Boston, Maverick Landing tenants Organization, and Chelsea and East Boston Police Departments (PD).

Somerville – Riverside (and predecessor organizations Somerville MHA and The Guidance Center) and North Suffolk have been central to these communities since the 1960s. Examples include Cambridge Health Alliance, Vinfen, Cambridge Safety Net, Somerville and Arlington PDs, Community Action Center of Somerville, CHNA 17, Saheli & South Asian Task Force.

Quincy – Riverside is headquartered in Dedham, has a major Outpatient/ESP hub in Norwood, and has a large CBFS presence in this area. Collaboration examples include Steward-Norwood Hospital, the Dedham Food Pantry, Norwood Housing Authority, Metro Suburban Recovery Learning Center, South Shore Mental Health Center, Abundant Table, Wellcare Physicians Group, Bay State Community Services, and the Dedham Police Department.

Lowell – The Edinburg Center provides clinical services and CBFS in this area. Examples include CHNA 15, Emerson Hospital, and the Sheehan Women's Program in Tewksbury.

Lynn – Lynn CHC and Riverside provide significant services for MassHealth recipients and both have BH Outpatient sites here. Examples include: Neighbor to Neighbor, Family Health Services of Greater Lynn, Bridgewell Project COPE, Lynn Shelter Association, Mass. Coalition for the Homeless, New American Center, Healthy Streets, Northeast Recovery Learning Community, and the Chase Community Sober Living Program.

Malden – Riverside and North Suffolk are deeply involved in these areas through Outpatient, CBFS, psychiatric day treatment and other services. Examples include: Wakefield, Melrose, Everett and Malden Housing Authorities, MGH Everett, Melrose Coalition Against Substance Use, Eliot Emergency Services, Comfort Home Care, Nizhoni Health Systems; Hallmark Health primary care services (Melrose/Reading); Melrose Wakefield Hospital, CHA Malden, Mystic Valley Elder Services, Kelly House Sober Living, and the Wakefield PD.

Woburn – Edinburg is headquartered in Bedford and both Edinburg and Riverside serve Woburn area communities. Examples of collaborations include Minuteman Elder Services, Lahey Health Center, Winchester Hospital, Mission of Deeds, Reading PD, Sober Steps to Solutions Woburn, Tri-Cap and the Reading Coalition Against Substance Abuse.
Framingham – Riverside has extensive services in the Framingham area such as Outpatient and ESP and Edinburg serves additional area towns. Examples include The Bridge House, CHNA 7 South, West Suburban Alliance of Gay, Lesbian, Bisexual, Transgender and Queer Youth, Milford Regional Hospital, Edward M. Kennedy Health Center- Milford, Golden Pond-Hopkinton, the Wayland Islamic Center, and Tri-River Family Health Center.
Southbridge – Riverside serves this area as the ESP provider and through Outpatient services and is planning to expand our Crisis Stabilization and Respite programs in the next few months. We have closely collaborated/subcontracted to Harrington Hospital for several years. Other examples include The Bridge of Central Mass., Alternatives Unlimited, Opiate Task Force of Worcester County, and UMass Memorial Medical Center.
Waltham – Riverside and Edinburg are both resources these communities rely on. Needham and Newton are both hub communities for Riverside services, including Outpatient and the Riverside Trauma Center. Examples include Needham's Coalition for Suicide Prevention, Needham Community Crisis Intervention Team, Ascentria Care Alliance-Waltham, Brandeis University, Newton Domestic Violence Task Force, and the Newton Health Department.

2. For all Service Areas for which the Bidder is bidding, the Bidder shall describe how it will grow its connections to the community in the Service Areas.
Riverside Community Partners is well positioned to continue growing connections in all the Service Areas we are proposing to serve as a BH CP: we all have significant local relationships to build on as our teams identify Enrollee's needs that may require new resources. One way that our organizations have expanded community connections over the years is through participation in local task forces, such as Suicide Prevention, Public Health initiatives, Substance Prevention Alliances, etc. We will continue these efforts. Also, we each have a broad range of services and our programs have opportunities to continually expand our reach into and connection with local services, hospitals, medical centers, municipal departments, advocacy groups, religious organization, and other services. We intend to leverage the breadth of our combined relationships and ongoing efforts across our Affiliated Partners to continue growing connections, within and across the cities and towns we serve. Sharing ideas, information, contacts, and opportunities will benefit each of our teams and most importantly the people we serve.

3. The Bidder shall describe its plans to ensure staff is informed of community resources over the course of the Contract Term.
As referenced earlier in this proposal, Riverside Community Partners intends to create a resource "library" that will be available electronically to each of our BH CP local teams. This will serve as a directory of social services, healthcare providers, advocacy and support groups, housing supports, and other resources within our Service Areas. It will have contact information for statewide organizations' local chapters and state agencies local site offices. We will utilize information already gathered by our organizations' many existing programs to get us started. Staff in all our local teams will access the "library" as needed and contribute to its ongoing additions and updates. New Care Coordinators will be trained in the use of this resource tool as part of their new employee orientation at each of the teams.

Section 7.3.C. Community Partner Supports and Activities

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Section 7.3 Initial DSRIP Participation Plan

7.3 C. Community Partner Supports and Activities (not to exceed 15 pages excluding attachments)

As the contracting organization, Riverside will establish and maintain data and monitoring systems that ensure all aspects of BH CP services and reporting are delivered in compliance with Attachment A of this RFR. This will include:

Coordination System and Databases**:** Riverside will maintain an electronic data base within our EHR that is dedicated to the Riverside Community Partners program. Among its features, the system will track each Assigned Enrollee's membership in a particular ACO/MCO or EOHHS agency, Enrollee relationship to Riverside or the Affiliated Partner, and the dates and documentation regarding all BH CP activities conducted. The system will also house the Enrollee specific electronic record for Enrollees assigned to Riverside's BH CP teams. Our Affiliated Partners will also retain their own electronic care coordination systems (or may opt to utilize Riverside's system) with Enrollee specific records and databases for documenting and tracking all activities related to outreach, engagement, care coordination, corresponding documents, and exchanges among team members for assigned Enrollees, and will submit reports to Riverside's dedicated electronic data base.

Monitoring Affiliated Partners' Adherence to BH CP Requirements**:** Affiliated Partners will provide electronic Member Status reports monthly to the Director of Riverside Community Partners so that Riverside can report electronically to EOHHS. In addition to reviewing Affiliated Partners' report submissions, the Director and Riverside's Vice President for Quality Management will routinely review Affiliated Partners' compliance with conducting all BH CP activities in the manner described in this response, and pursuant to compliance with all requirements of the Model Contract through record sampling and review of any communications regarding the conduct or performance of our Community Partner Activities. The Director will also meet with Affiliated Partners' Team Leaders at least quarterly, to discuss/share processes, challenges, any unresolved grievances, and best practices.

1. Outreach and Active Engagement

The Bidder shall describe how it plans to satisfy the Outreach and Active Engagement requirements described in Section 2.3.A of Attachment A, using evidence-based or emerging practices, as appropriate. Specifically, the Bidder shall describe the Bidder's:

Pursuant to Section 2.3.A. of the RFR, Riverside, with our Affiliated Partners will "…develop, implement, maintain, and adhere to a protocol for Outreach and Active Engagement of Assigned Enrollees." Engagement is a process, not an event; our primary method for engaging enrollees is to build trust based on empathy, respect and finding common ground for working together.

Receiving Assignments/Referrals: The Riverside Community Partners' Director will be the point of entry for referrals of potential Enrollees from ACOs/MCOs, EOHHS and other providers. She will determine which Affiliated Partner will receive the Assigned Enrollee, considering information received including the Enrollee's address in relation to teams' location, whether the Assigned Enrollee has a pre-existing relationship with or request a particular Affiliated Partner. She will send all information received about the Assigned Enrollee to the designated BH CP team to begin outreach and engagement activities.

Overall Outreach and Engagement Process: Upon receipt of the name and related information of an Assigned Enrollee from the Director, the Clinical Care Manager/Team Leader will determine which Care Coordinator will be assigned. The Care Coordinator will begin outreach to the Assigned Enrollee and attempt to schedule a face-to-face visit and provide information about the benefits, design and purpose of CP supports, how to engage with the Care Coordinator, how to opt out of CP participation, and how to formally participate if s/he wishes. If telephone contact cannot be established after three attempts, the Care Coordinator may mail a letter to their home address outlining the program and providing a way for the Enrollee to contact him/her. Because many Assigned Enrollees may be people we already serve, we will also reach out to our existing staff in other programs (i.e. CBFS, Outpatient) to assist us in connecting with referred individual Team staff will conduct at least one Outreach activity with each Assigned Enrollee within 30 days of assignment, will make at least one attempt to have a face to face visit with the Assigned Enrollee within the first three calendar months of assignment, and will document these activities in their electronic care coordination system.

Outreach to and Engagement with Enrollees with Language Barriers or Special Needs: If we are aware of an Assigned Enrollee with whom we cannot use traditional communication mechanisms, such as a non-English speaker or an individual who is deaf or hard of hearing, we will make every effort to accommodate any needs the potential barrier presents. When possible, we will match the Assigned Enrollee with a Care Coordinator who speaks his/her language. We may also confer with the Enrollee's PCP who may know of friends, family members or others that the Enrollee is comfortable relying on for interpretation assistance to help us to make initial contact with the Assigned Enrollee. Then we will make arrangements for ongoing interpretation assistance depending on this resource availability, and the Assigned Enrollee's expressed preferences. We have also been exploring the use of a new earbud "real time" interpreter technology that we may provide to the Assigned Enrollee at a first face-to-face visit. This technology is simple to use and while it is completing the beta testing phase, may prove to be highly effective and inexpensive enough for us to use it for language interpretation needs after a first visit. We will use similar strategies for communicating with an Assigned Enrollee who is deaf or hard of hearing, working with his/her PCP, as appropriate, to understand any special accommodations that the Assigned Enrollee is comfortable using and incorporate these into our outreach, engagement and assessment, person-centered planning and care management processes (i.e. sign language or communication board). As needed, communication specialists may be accessed through the Massachusetts Commission for the Deaf and Hard of Hearing.

Riverside Community Partners Care Coordination staff will receive training on and/or have experience working with individuals with behavioral health disorders and will conduct their outreach, engagement and care coordination activities using recovery oriented principles and motivational interviewing techniques. Further, there is significant evidence from both Riverside and its Affiliated Partners' experience and from what we know of best practices from research on collaborative care models, that using peers on a care coordination team is effective in engaging and working with persons with serious mental illness, as they often serve as role models for individuals who may be ambivalent about change. It is our goal to staff the teams with at least one team member who is a recovery specialist/person with lived experience.

a. Planned strategies for outreaching to and engaging with Assigned Enrollees, including individuals who are homeless and hard to reach, within the timeframes specified in the Contract;

In the case of any Assigned Enrollee who is known to be homeless or hard to reach, staff will reach out to the PCP or referring provider, who may be familiar with where the Assigned Enrollee might be found. Initial attempts to reach him/her may be made by the Care Coordinator through visits to shelters that may be frequented by the Assigned Enrollee or to soup kitchens, food pantries, and/or day programs. If this information is not in the Assigned Enrollee's record, the Care Coordinator will reach out to family and/or behavioral health or social service providers known to be working with the individual to help locate the Enrollee. In some cases, we may have a phone number and address for an Assigned Enrollee but still be unable to reach him/her via telephone during a business week day and after hours contact attempts will be required.

Riverside's previous experience in a grant funded care coordination pilot of using the Critical Time Intervention model, developed by the CUCS Institute, taught us the benefits of focused, time limited services to engage homeless individuals to transition into new housing and/or establish or improve relationships with providers. This model engages a more transient population by identifying two or three essential areas the person is most interested in resolving and simple, achievable solutions. It provides more frequent contact at the time of enrollment, with decreasing frequency over time, reducing the risk of perceived dependency and reinforcing the use of natural supports and collateral providers. Ongoing engagement might be better received when understood as a series of time limited efforts around identified goals.

b. Planned Strategies for outreaching to and engaging with Assigned Enrollees with Substance Use Disorders;

We will apply our understanding of stages of change and utilize motivational interviewing techniques in attempts to engage individuals with SUD. For example, when first assigned an Enrollee, the information we receive may not indicate whether the person is actively using substances and pre-contemplative, actively engaged in recovery or somewhere in between. Inquiring about the person's concerns, goals, and preferences and avoiding imposing judgment or expectations ahead of the individual's readiness will be key to laying the foundation for future engagement in treatment and self-help activities as readiness occurs. If the Enrollee with a substance use disorder (SUD) is also homeless or hard to reach, the assigned Care Coordinator may seek out the Enrollee at a Methadone or Suboxone clinic or recovery groups s/he may attend in addition to those activities described above. This strategy would be used with great sensitivity so that the Assigned Enrollee does not feel that his/her his privacy has been violated; we would not want to undermine his/her attendance at substance use treatment and services.

c. Planned process to obtain and document Assigned Enrollee's agreement to participate in CP Supports through a participation form.

During the initial contact with the Assigned Enrollee the Care Coordinator will explain the value and range of CP supports and how to formalize participation by signing the confirmation form. The Care Coordinator will also explain what protected information will be solicited from the Assigned Enrollee and how it will be used and shared in the delivery of CP supports as well as how a section of the Enrollee's future plan of care, the Wellness Recovery Action Plan (WRAP) Plan can be kept confidential and that the Enrollee can determine whom may see it.

When an Assigned Enrollees agrees to participate, the Care Coordinator or Clinical Care Manager will obtain the signed participation form and requisite consents from the Enrollee. In accordance with Riverside's approved Quality Management plan, the Care Coordinator will then obtain the Assigned Enrollee's written authorization to the uses and disclosures of his or her Protected Information (PI) as necessary for providing CP Supports. Team members will also document each case in which Assigned Enrollees decline participation. Once the Assigned Enrollee has signed the form, the Care Coordinator will elicit his/her preferences and needs related to future contact including what special accommodations might be necessary for ongoing telephonic communication and face-to-face visits, and to conduct the Comprehensive Assessment. If special arrangements must be made for these contacts, the Care Coordinator will ensure other staff are prepared. Within five days of obtaining the Assigned Enrollee's signature on the participation form, the Clinical Care Manager will formally assign the Enrollee to a Care Coordinator on the team. In most cases, this will be the Care Coordinator who outreached to the Assigned Enrollee. The Clinical Care Manager will also open a Care Coordinator record for the Enrollee in the Riverside Community Partnership electronic system and will work with the Assigned Enrollee to schedule the assessment visit.

2. Comprehensive Assessment and Person-Centered Treatment Planning
The Bidder shall describe how it plans to satisfy the Comprehensive Assessment and Person-Centered Treatment Planning requirements described in Section 2.3.B of Attachment A, using evidence-based or emerging practices, as appropriate. Specifically, the Bidder shall describe:
a. The Bidder's process for conducting Comprehensive Assessments, including how the Bidder will ensure the Assigned Enrollee participates in the assessment process. The Bidder shall include a copy of proposed assessment tool(s) as an attachment;
Riverside Community Partner's process for conducting a comprehensive assessment with each Assigned Enrollee who signs a participation form is as follows: The Riverside Community Partners Program Assessment tool will be used to identify each Enrollee's immediate care needs, current services, and any care coordination or management services being provided by state agencies such as the Departments of Mental Health (DMH), Developmental Services (DDS), Massachusetts Rehabilitation Commission (MRC), Massachusetts Commission for the Blind (MCB), Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH), Department of Children & Families (DCF), or Department of Youth Services (DYS). It will also assess the Enrollee's perceptions of wellbeing, self-reported strengths, and any opinions about the current caregivers and services.

The initial assessment will be conducted by the Care Coordinator (or Clinical Care Manager, at times), who will also collect the medical history information including current medical needs and prescribed medications. The Care Coordinator will conduct the in person assessment and will travel to the individual's home or meet with them in the community at an agreed upon location or at a Riverside or Affiliated Partner's site. As described above, we will make accommodations as necessary to ensure that the Assigned Enrollee can actively communicate in and understand the assessment process. This may mean that an interpreter or interpreter technology will be used during the comprehensive assessment.

No assessment will be considered complete without the participation of the Enrollee, as documented in the Enrollee electronic record. The completed Comprehensive Assessment will be given to one of the team's Nurse Care Managers for review and for follow-up with medical providers and the Enrollee for additional information, as necessary. The Nurse may find it necessary to meet with the Enrollee before considering the assessment completed, if, for example, an individual has a complicated medication regimen. We will explore using telehealth technologies, to enable us to have virtual visits with individuals, if they also have access to computers or smart phones. Following the Nurses review, the Clinical Care Manager will provide final review and approval of the entire Comprehensive Assessment.

We will complete the Comprehensive Assessment within three calendar months of the Assigned Enrollee's Assignment to Riverside Community Partners (unless an Enrollee has an existing comprehensive assessment which was conducted within three months prior to the Enrollee's assignment to the Riverside CP, in which case that comprehensive assessment shall be utilized for the Enrollee), and annually, thereafter. Our software will provide planned reminders to support this effort. Each visit related to the assessment and the assessment contents will be documented and stored in our Care Coordination system. We will communicate the results of each Comprehensive Assessment with the Assigned Enrollee's Care Team, ACO/MCO, and other providers who serve the Assigned Enrollee, including state agency or other case managers, as appropriate.

The proposed Riverside Community Partners Comprehensive Assessment Tool is provided as an Attachment following this section. It includes all components listed in Section 2.3.B.1.b.1-2. There are three additional sets of questions that we have added to the comprehensive assessment tool that are not explicitly required per the RFR, but which Riverside and its Affiliated Partners believe are important and valuable to include. First, we added questions from the CAGE screening tool, recommended by the National Institute of Alcohol Abuse and Alcoholism, which are used to identify potential problematic drinking behaviors. The responses provided by individuals to these questions help guide the assessor in asking additional questions, the responses to which yield a more comprehensive picture of an individual's use of substances and interest in changing behavior. Second, we have added the evidence-based Modified Morisky Scale, a set of questions and a score, which provides information for determining where an individual is in terms of his/her knowledge and motivation regarding psychiatric medications. As with the CAGE screen questions, responses to these questions are particularly useful for ensuring person-centered planning discussions. Last, we have added questions regarding individuals' history of trauma, falls, education and employment and concerns, preferences and goals related to each area. The inclusion of this additional information in the assessment process is critical in understanding individuals holistically and helps the ensuing person-centered planning discussions delve more deeply into what services and supports will best address the Enrollees' concerns, build on his/her identified strengths and meet his/her needs.

In addition to the Comprehensive Assessment Tool, a short questionnaire may be included in the initial assessment process to collect information to be used in our annual quality initiative and stored in a discrete section of the Assigned Enrollee's individual electronic record.

b. The Bidder's process for conducting Person-Centered Treatment Plans. Such description shall include:
1) Planned processes for developing the Person-Centered Treatment Plan, including ensuring the Assigned Enrollee participates in the process;
Following completion of the Comprehensive Assessment, the Care Coordinator will invite the Enrollee to participate in the process of developing and completing the Person-Centered Treatment Plan (referred to hereafter as the Person Centered Care Plan) which will be completed within three calendar months of the Enrollee's assignment to Riverside Community Partners.

Riverside and our Affiliated Partners embrace person-centered planning - a process directed by the participant, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the participant - as the appropriate way to develop a plan of care with any individual. Our Care Coordination staff will be trained in and practice person-centered planning and Shared Decision Making with people served, and will use this approach in creating the Person Centered Plan in partnership with the Enrollee. We will utilize the guidance of the Substance Abuse and Mental Health Services Administration and Dr. Patricia Deegan's publications and other relevant guides. Development of the Person-Centered Plan entails talking with the Enrollee and others the Enrollee chooses about the findings from the Comprehensive Assessment and determining what if any conditions or circumstances the Enrollee seeks to affect with a care plan, what the specific content and areas of focus of the plan will be, and what strengths the Enrollee will build on to strive for change and recovery.

A Person-Centered Planning process is driven by the individual, but works best when it includes other people, both formal and informal caregivers who are chosen by the Enrollee to also participate and who can contribute valuable information to the process. Prior to scheduling the face-to-face planning meeting with the Enrollee, in keeping with the Person-Centered philosophy, the Care Coordinator will discuss with the Enrollee whom s/he wants to include in the discussion and on the Care Team in addition to the PCP and other specialists who may already be a part of the team. These identified individuals will be invited to participate in the meeting in person or by teleconferencing.

In developing the plan, the conversation with the Enrollee may be framed in terms of SAMHSA's Eight Dimensions of Wellness, information about which is captured in the comprehensive assessment. The areas of life included in these Eight Dimensions include: emotional, financial, social, spiritual, occupational, physical, intellectual and environmental. The Care Coordinator will review findings in each area with and provide information to the Enrollee regarding identified issues and potential options that might address them, including the advantages/disadvantages or risks/benefits of each. The conversation will also focus, in discussing each domain, on what the Enrollee regards as his/her strengths, what s/he values, and any goals for change, and how the options for addressing issues may use the Enrollee's strengths and align with his/her overall goals.

Should the Enrollee seek or need LTSS service needs, the Care Coordinator will review with the Enrollee his/her choices for specific LTSS services, programs and providers (including any providers with which the Enrollee is already engaged for LTSS supports) to determine what LTSS services and providers will best meet his/her needs.

All of the discussions about services, choices and needs will be documented by the Care Coordinator, including documentation that at least two choices of LTSS service providers were given. Similarly, the Care Team in conjunction with the ACO/MCO may identify needs that may be met through the provision of Flexible Services. These possible services and supports will be explained to the Enrollee and if desired and appropriate, and the ACO/MCO is willing to authorize, will also become a part of the Person-Centered Care Plan.

All Riverside Community Partner staff will be trained in using the Shared Decision Making process for discussing psychotropic medications and in assisting Enrollees to use the free, online Shared Decision Making electronic tools available through the Substance Abuse and Mental Health Services Administration website to help determine whether they will be part of the Enrollee's person-centered plan of care. In our experience, Care Coordinators must demonstrate considerable sensitivity in talking with Enrollees about medications. Sometimes an individual will not wish to discuss medications with a new caregiver without first establishing some level of trust for that caregiver. Therefore, it will be potentially important after the creation of the Person-Centered Care Plan is completed, that the Care Coordinator periodically check-in with the Enrollee about medication use. The Person-Centered Plan will include a section on medications, including a description regarding how and with what frequency and Enrollee would like reminders or assistance with adherence to medications. In some cases, an Enrollee may be interested in utilizing a reminder App on his/her cell phone. Such a preference will be documented in the care plan and the Care Coordinator will help the Enrollee obtain, download and operate the medication alert APP. It will also be clear by the conclusion of the Person-Centered Care planning process whether anyone else should be notified in the event that an Enrollee is not adhering to medication recommendations. This plan will be followed carefully by Care Team members so as not to harm the Enrollee's trust.

In addition to the requisite components of the Person-Centered Treatment Plan listed in section 7.3.B.2 of Attachment A of the RFR, Riverside Community Partners Care Coordinators will invite each Enrollee to discuss developing and/or incorporating an existing, WRAP plan, a recovery oriented best practice into his/her Person-Centered Plan. A WRAP is an Enrollee's personal safety plan, which describes from his/her perspective, certain activities that may assist when s/he may be feeling anxious or despairing. It includes description of: signs and symptoms that the Enrollee has noted should alert others that s/he is in distress, times/seasons/holidays or other events such as the anniversary of a death of a loved one that the Enrollee notes can trigger a difficult emotional time, self-identified coping skills and strategies, steps s/he suggests others can take to help avoid the need for hospitalization, and additional steps that caregivers and others working with the Enrollee can take to help support the Enrollee in maintaining healthy behaviors. The WRAP typically also includes the Enrollee's preferred hospital, and who the Enrollee would want notified in case of an emergency. Should the Enrollee have a WRAP plan in his/her Person-Centered Care Plan, the Care Coordinator will discuss the benefits of sharing this element of the plan with the whole team but will explain that the Enrollee may direct with whom the WRAP plan may be shared.

2) Planned processes for documenting the Person-Centered Treatment Plan;

The person-centered plan will include all required elements listed in Section 2.3.B of Attachment A of the BH CP RFP. If applicable, the Enrollee's preferences regarding reminders about taking prescribed medications and/or a section within the Crisis plan designated as the Enrollee's WRAP. We will not consider the Person-Centered Care Plan to be complete unless the Care Coordinator can document that the Enrollee participated in the planning process to the extent s/he chose, and has approved the final plan.

When the written Person-Centered Care Plan is completed, Enrollee participation is documented, and it is approved and signed by the Enrollee and the Enrollee's PCP (or PCP's designee), it will be stored electronically in the Riverside Community Partners EHR. It will then be shared/transmitted electronically with the Enrollee's PCP or PCP Designee and with all other parties who need the Plan in connection with their treatment of the Enrollee, provision of coverage or benefits to the Assigned Enrollee, or related operational activities involving the Enrollee, including members of the Enrollee's Care Team, ACO/MCO, and other providers who serve the Enrollee, including state agency or other case managers for whom permission to provide information has been given.

3) Planned process for updating the Person-Centered Treatment Plan;
Riverside and our Affiliated Partners will reassess and update each Enrollee's Person-Centered Care Plan at least every six months and more frequently, as required pursuant to the requirements of section 2.3.B.2.f of the Model Contract. During the monthly (or more frequent) encounters with Enrollees, our Care Coordinators will monitor each Enrollee's progress on goals, expressions of how s/he thinks things are going, changes in health status, recommendations by other caregivers or providers, recommendations for follow-up regarding medical conditions or changes in medical status, and how/whether it appears that the Enrollee activities comport with what s/he indicated to be his/her intentions when agreeing to the plan. Reassessments of the Person-Centered Care Plan will be scheduled earlier than six months should the Enrollee's Care Coordinator determine that this is necessary and/or the Assigned Enrollee requests it. At each reassessment, the person-centered plan will be reviewed comprehensively and all sections will be updated, new goals set and other modifications made, as necessary and appropriate. The Riverside EHR will keep track of when changes to the Plan of Care occur and will store and date all versions of each Enrollee's Person-Centered Care Plan.

4) Planned process for ensuring the Assigned Enrollee and the Assigned Enrollee's PCP or PCP Designee approves the Person-Centered Treatment Plan.
At the conclusion of the person-centered planning process, the Care Coordinator will transmit the completed draft plan to the Enrollee's PCP and request his/her review. The Enrollee will also be given a printed copy. The plan may be prepared and shared with the Enrollee (and/or guardian) in alternative formats, such as an audio tape, and/or translated into the Enrollee's primary language as necessary, so that the Enrollee can fully and easily access it. The Care Coordinator will review the completed plan of care with the Enrollee and his/her guardian as necessary, to be sure that it reflects what the Enrollee understood it would include and that the Enrollee/guardian approves of the plan. The Care Coordinator will make any needed edits to the plan based on Enrollee/guardian or PCP feedback and share the final versions with the PCP and the Enrollee.

When the written Person-Centered Care Plan has been completed, reviewed and agreed to, the Enrollee/guardian and the PCP will be asked to sign to acknowledge acceptance. Accommodations will be made for a proxy to sign on behalf of the Enrollee, as necessary, in the event that the Enrollee cannot physically do so his/herself. The person-centered plan of care will be printed and a copy will be given to the Enrollee to keep. This same process will be followed after any updates are made to the plan.

3. Care Coordination and Care management.
The Bidder shall describe how it plans to satisfy the Care Coordination and Care Management requirements described in Section 2.3.C of Attachment A, using evidence-based or emerging practices as appropriate. Such description shall include:
a. How the Bidder will identify all stakeholders (e.g., providers, state agencies, community organizations) involved in an Enrollee's care;
As noted in our response in section 7.3.C.1 above, each Enrollee will be assigned to a Riverside Community Partners team in his/her geography. The Clinical Care Manager/Team Leader of the each team will receive all information available from the referring entity and provide this to the assigned Care Coordinator. The Team Leader and/or Care Coordinator will request additional information about potential stakeholders involved in the Enrollee's care as needed from the ACO/MCO or other referring entity and from the Enrollee, including the name and contact information for the Enrollee's PCP, behavioral health clinician(s), if any, other case managers, advocates, and specialists involved in the Enrollee's care. Based on initial answers, the Care Coordinator may still need to ask for additional stakeholder information from family members, the PCP, behavioral health providers, etc., with the Enrollee's permission. As the assessment takes place, additional information may be gleaned about the Enrollee's current relationships with other caregivers including Recovery Support Navigators, Community Based Flexible Support (CBFS) providers, LTSS providers, substance use services providers, and other formal providers and informal caregivers.

b. How the Bidder will exchange information with such stakeholders;
Riverside and our Affiliated Partners will establish dedicated telephone numbers for Riverside Community Partners – a central number as well as local numbers. All Care Coordination staff will be reachable for verbal communication through these numbers. Written communication about the Enrollee between our program and members of Enrollee's Care Team or other stakeholders involved in the Enrollee's care, who have been authorized via signed consents to receive information about the Enrollee, will be conducted using the Riverside HIPAA protected electronic care coordination system that we will establish and utilize for the Riverside Community Partners operations. All data exchanges from/to Riverside Community Partners for all ACOs/MCOs and EOHHS will conform to all Mass HIway secure exchange standards and to approved data standards (CCD, HL7, etc.). Written communication with additional stakeholders will be accomplished, as necessary through encrypted email or through mailed hard copy.

c. How will the Bidder identify and organize members of the Enrollee' care team;
At the implementation of Riverside Community Partners, Riverside and our Affiliated Partners will have established core teams consisting of a Clinical Care Manager/Team Leader, Nurse Care Managers (RN and LPN), bachelor's level Care Coordinators, and a Medical Director who will consult and assist as needed regarding individual Enrollees. As noted in our description

regarding outreach and engagement activities above, it is our intention that ideally each BH CP team will include peers, i.e., individuals with mental health diagnoses and those in recovery from substance use disorders, as Care Coordinators. Each team's Clinical Care Manager/Team Leader will have final responsibility for the completion and approval of assessments and Care Plan Updates, semi-annually, as required, and whenever else that it may be necessary. The Nurses will have responsibility for all medical portions of the care plans, including medications.

The assigned Care Coordinator is responsible for organizing the Care Team for assigned Enrollees, including but not limited to required staff from within the BH CP team and additional members at the Enrollee's discretion, such as family members and other formal and informal caregivers or advocates. With the Enrollee's permission, the Care Team may also include other specialists and clinicians who are responsible for the specific services that they authorize and/or directly provide per the approved care plan. If Case Managers from state agencies are involved with the Enrollee, the Enrollee will be asked whether they may participate on the Care Team and the Care Coordinator will determine the most sensible and non-duplicative manner for their involvement with respect to ongoing care coordination activities. With guidance from the Care Coordinator, Care Teams will employ a person-centered approach, to ensure that they are formed and operate according to the needs and preferences of the Enrollee.

The Care Coordinator will finalize the Enrollee's Care Team members prior to commencement of the Person-Centered Planning process. Specific Care Team members whom the Enrollee agrees should participate in the Person-Centered Planning Process will be invited to join the Person-Centered Planning meetings when they commence. After the comprehensive assessment and Person-Centered Care Plan have been completed, all Care Team members will be invited to attend all subsequent telephonic and in person care team meetings. The first full meeting of the Care Team will include the Enrollee and will occur six months after the Enrollee has enrolled, or sooner. Names and contact information of Care Team members will be put in the Riverside EHR and updated as necessary by the Clinical Care Manage/Team Leader and/or Care Coordinator.

Once the Person-centered Treatment Plan has been completed, the Enrollee's Care Coordinator will contact the Enrollee to provide any support necessary to ensure that the Enrollee is able to access the formal and informal care delineated in the plan. In this conversation, the Care Coordinator will also review any information to be communicated from the PCP, specialist or other care providers through the Care Coordinator to the Enrollee, and/or provide well-visit, medical, prenatal, outpatient behavioral health, or preventative care reminders. The Care Coordinator will assist the Enrollee to follow-up on any new referrals to providers or services in the manner that the Enrollee prefers as laid out in the Person-Centered Care Plan. The Care Coordinator will also coordinate the Enrollee's attainment of any LTSS services identified and agreed on in the care plan. This will include assisting the Enrollee to reestablish existing relationships and/or identifying LTSS providers that serve or might serve the Enrollee and facilitating communication between the Enrollee, the ACO/MCO and these providers as needed.

The Care Coordinator will track referrals s/he made and appointments s/he scheduled for health-related services for the Enrollee, and will follow-up with the providers by telephone after scheduled visits to identify if/when the Enrollee missed a visit. In the case of missed visits, the Care Coordinator will attempt to reach the Enrollee by telephone to determine whether there are

additional supports, such as assistance with accessing transportation, which s/he may need to be able to make it to appointments. Information about access needs and supports recommended will be documented in the Enrollee's electronic record and communicated to other Care Team members as necessary. The Care Coordinator will ensure that s/he obtains information about medical visits made by the Enrollee immediately post-hospital discharge and share it with others on the Care Team as necessary.

The Care Coordinator will also monitor how the Enrollee utilizes prescribed medications that are identified in the Person-Centered Care Plan. In the event that providers have made new medication recommendations, the Care Coordinator will follow-up with Enrollees (with the assistance of one of the team Nurses, as necessary) to discuss how the medications are working, discuss any questions that the Enrollee may have about his/her new prescriptions, confirm that the Enrollee intends to use the new medications, discuss any concerns the Enrollee may have about their use and/or review their decision to stop or decline a medication. These discussions may be further facilitated by assisting the Enrollee to utilize Shared Decision Making tools regarding psychotropic drug use as noted above. The Care Coordinator will defer to the Enrollee's expressed preferences regarding how and when to discuss medications.

d. How the Bidder will ensure effective ongoing communication across all stakeholders, including exchanging essential documentation.

As noted above, all information relating to our Care Coordination supports and activities relating to the Enrollee, and all of the communications among Stakeholders about the Enrollee will be tracked and stored utilizing either Riverside's Care Coordination system or the Care Coordination system of the Affiliated Partner, depending on the Enrollee's assignment. Riverside and its Affiliated Partners' will communicate directly with the Enrollee's providers and ACO/MCO about care coordination matters electronically through HIPAA protected mechanisms described in the response to section 7.2.E.

This includes sharing key documents with Care Team members, such as the Person-Centered Care Plan and any updates to it. Any relevant verbal information communicated among stakeholders in the conduct of care coordination activities will also be documented in the specific electronic record within the Riverside or Affiliated Partner care coordination system. It will also likely be necessary at times for Care Team members to send or receive some information to/from certain clinicians or other Stakeholders via facsimile, such as blood test results. In the event that any information, such as a change in the Care Plan relating to medication, is sent to a Care Team member via facsimile, it will also be scanned and stored in the electronic record for the Enrollee. Riverside and its Affiliated Partners will document in the Enrollee's electronic record all calls about the Enrollee's care coordination and related activities, such as outreach attempts and calls to or notices sent to other providers around scheduling.

4. Care Transitions.

The Bidder shall describe how it plans to satisfy the Care Transitions requirements described in Section 2.3.D of Attachment A, using evidence-based or emerging practices as appropriate. Such description shall include all the necessary steps the Bidder will take to ensure the Engaged Enrollee's stability and satisfaction following a transition of care.

Our planned practices for managing care transitions will be guided by the requirements described in this RFR and by best practices identified by the Center for Healthcare Research and Transformation. The Center's guidance includes the following components:

Comprehensive discharge planning should be conducted with all team members and follow-up should occur one to three days post discharge – The Care Coordinator will seek to be part of any transition planning, ensuring that the discharging provider and any new community referral sites are aware of the Enrollee's Person Centered Care Plan, including any accommodations the Enrollee may need and that the Enrollee's preferences are heard. The Care Coordinator will contact the Enrollee's physician, other Care Team members and seek to have at least one other Care Team member participate in discharge planning meetings. The Clinical Care Manager or on of the Nurse Care Managers may directly assume this responsibility in situations where the transition is particularly complex, but in all cases will be available to guide and support the Care Coordinator throughout all phases of care transitions.

Complete and timely communication of discharge information should occur using a standardized format – The Care Coordinator will seek essential information such as diagnosis, test results, medication lists and rationale for medication changes, and contact information for the discharging physician. This, along with all discharge plans will be entered into the electronic Care Coordination system and shared as appropriate with the Enrollee's physician and other Care Team members, including the Nurse Care Manager.

Medication reconciliation should occur at each transition – One of the team Nurses will review the accuracy of medication lists and dosages and look for contraindications in consultation with the Enrollee's primary care physician and or the Medical Director as necessary.

The Enrollee and caretaker education should use the "teach back" method – The Care Coordinator will meet with the Enrollee within three business days of discharge and will provide support and education around any new diagnoses, medications changes, time of follow-up appointments, self- care, warning signs and what to do if problems arise. To ensure information is understood, the Care Coordinator will ask the Enrollee/caretaker to restate instructions or concepts in his/her own words. The Enrollee will also be asked about his/her experience and any feedback will be reviewed by the Enrollee's team and added to the Care Plan.

Open communication between providers based on clearly defined responsibilities – The Care Coordinator will facilitate information sharing among Care Team members, insuring that each involved person understands the role s/he will play in assisting the Enrollee post discharge and providing contact information for the discharging provider, as needed.

Follow-up visits with the designated provider after discharge should be prompt – The Care Coordinator will assist the Enrollee in securing rapid (generally within 7 days) post discharge appointments as appropriate (i.e. with the Enrollee's Outpatient BH provider) monitor that the Enrollee attends.

5. Medication Reconciliation

The Bidder shall describe how it plans to satisfy the Medication Reconciliation requirements described in in Section 2.3.E of Attachment A using evidence-based or emerging practices as appropriate.

The Nurses on each BH CP team are responsible for conducting the Medication Reconciliations for Enrollees discharged from an inpatient stay within 3 business days of the date of discharge, in accordance with Section 2.3.E of the Model Contract. Once the Care Coordinator is notified of an impending discharge s/he will alert one of the team Nurses, who will serve as liaison between the Enrollee's PCP and the hospital discharge staff regarding medication orders, as appropriate. Once the Enrollee has been discharged, the Nurse will coordinate with the appropriate Care Team member to ensure that the medication orders are filled accurately and quickly. If new medications have been prescribed, the Nurse, in conjunction with the Care Coordinator, and in deference to the Enrollee's Person-Centered Plan with respect to psychiatric medication, will talk with the Enrollee to determine whether s/he understands the medications and why/how they will be administered, encourage use of prescribed medications, and ascertain whether the Enrollee intends to comply with recommendations. If an Enrollee has had substance use issues or previously abused prescriptions, this would have been addressed in the medication portion of the Person-Centered Care Plan, and the designated strategies developed to help the Enrollee curtail such abuses will be employed by the Team. In the event that the Enrollee is discharged to a new treatment facility setting and has new prescriptions, the Nurse, Care Coordinator and Enrollee will discuss how and where the prescriptions will be filled, including identifying the pharmacy the Enrollee intends to use and assisting the Enrollee to set up transportation to the pharmacy if needed. If the Enrollee participates in a MAP program, the Care Team will share the medication order forms and information with the MAP provider. In the event that medication administration by a nurse will be required, the nurse and Care Coordinator will help make arrangements with area providers such as visiting nurses to provide this service.

These procedures are in keeping with guidelines generated by the Agency for Healthcare Research and Quality for successful Medication Reconciliation. Additional recommended steps we will seek to include are: Developing a single, easy to follow medication list for the Enrollee/caregiver; eliminate unnecessary redundancies in the process; educate the Enrollee/caregiver about the important role each plays in the process, and clarify other Team members' roles and responsibilities.

6. Health and Wellness Coaching

The Bidder shall describe how it plans to satisfy the Health and Wellness Coaching requirements described in Section 2.3.F of Attachment A using evidence-based or emerging practices as appropriate. Specifically, the Bidder shall describe proposed procedures for conducting Health and Wellness Coaching activities, including:

Riverside Community Partners will ensure that the Health and Wellness Coaching requirements described in 2.3.F of Attachment A, including educating the Enrollee on how to reduce high risk behaviors and health risk factors, assisting the Enrollee in establishing links to health promotion activities, and assisting the Enrollee in setting health and wellness goals, are satisfied as follows:

a. Health and wellness education, coaching and health promotion programs the Bidder intends to utilize or follow; and

As part of the Person-Centered Planning Process and following identification of the Enrollee's health and wellness goals and incorporation into the Care Plan, the Care Coordinator and/or Nurse will work with the Enrollee to determine what supports the Enrollee might be interested in and which s/he can receive through his/her PCP's office, ACO/MCO, or through other community based health and wellness support services. Care Coordinators will have on hand pamphlets and other materials, including a full list of Health and Wellness supports that are available at the BH CP and Affiliated Partners' sites. We also intend to develop wellness and health behavior video-conference trainings over the course of the BH CP program to offer to groups of Enrollees interested in particular topics (i.e. healthy eating habits, smoking cessation).

In developing new programming, Riverside Community Partners will conduct a comprehensive review of the wealth of wellness strategies and resources identified on the SAMHSA-HRSA Center for Integrated Health Solutions web site when developing its best practices Health and Wellness Coaching curriculum. SAMHSA identified these factors to be more effective than other approaches: program format (health promotion programs of three months or longer which include an education manual and activity- based approach; weight management which incorporates a nutritional component; physical fitness activity based (vs didactic) programs; integrated physical fitness and nutrition programs; and objectively and reliably measuring lifestyle behaviors (such as tobacco use or nutrition, physical fitness and weight outcomes). These factors will guide our program planning.

b. Methods for ensuring the Engaged Enrollee's goals for the health and wellness programs are recorded and tracked in the Engaged enrollees' Person-Centered Treatment Plan.
A discrete section of the Enrollee Care Coordination record will be dedicated to health and wellness goals so that they are a formal focus area. The Care Coordinator will document any activities that the Enrollee participates in which s/he agrees should be added to the Person-Centered Care Plan, and these activities will be tracked. We expect that Enrollees' initial interest in participating in health and wellness programs will vary, and for some people, such goals may only be agreed to over time, as the relationship with their Care Coordinator and other Care Team members deepens. Initially, some people may only be interested in receiving information about their high risk issues and/or steps they can take on their own to improve their health. When goals do include a formal wellness program (either initially or at a later time), participation will be tracked in the Enrollee's record. The Care Team in conjunction with the Enrollee and his/her PCP will work out specifics of what the Enrollee seeks to focus on and how, and what ongoing reminders or supports will be provided. Revisions and additions to the Care Plan will be documented in accordance with the Enrollee's agreed upon goals.

7. Connection to Community and Social Services
The Bidder shall describe how it plans to connect Engaged Enrollees to social services and community resources, including but not limited to ensuring ongoing connections to community resources and social services.
a. The Bidder's plans to evaluate Engaged Enrollees for social service needs, including the Bidder's proposed screening tool(s), if any;
Our Care Coordinators will evaluate the Enrollees' social service needs and desires as part of the Comprehensive Assessment and the Person-Centered Care Plan development. The Care Coordinator will gather additional information about Enrollees' community and social

service/flexible supports needs and desires through a social services needs assessment tool that we will develop with our Affiliated Partners for use in conjunction with the Comprehensive Assessment. The Comprehensive Assessment tool touches on areas of community and social service needs and will help the Care Coordinator determine which areas to delve into further with the Enrollee. The Social Services assessment tool will help identify existing and possible flexible services and supports might help address the Enrollee's needs. For example, the social services tool will contain many more questions related to the Enrollee's residence and how safe and healthy a living environment it is, whether or not the Enrollee has a means of transportation from or near his/her home to enable attendance at medical appointments, etc. and whether the Enrollee conveys the need to find alternative housing. In the event that finding other housing is critical it will elicit information from the Enrollee about housing needs and preferences. The tool will have a series of questions that are similarly more in depth under each of the areas noted in the description of Section 2.3 G of the Model Contract.

Following this assessment, the Care Coordinator, drawing on the support of others on the Enrollee's Care Team such as their case managers from state agencies, the PCP and representatives from the ACO/MCO, as appropriate will assist the Enrollee in identifying and accessing relevant community-based, social and Flexible Services and resources, including non-Medicaid services, informal supports, home and community based waiver services, and other services and programs including those listed in Section 2.3.G of the Model Contract, that will potentially help meet the identified needs and assist the Enrollee in maintaining as much independence as possible.

b. How will the Bidder ensure its Care Coordinators are familiar with a wide breadth of social services and supports, and providers of these supports.
Riverside Community Partners has been established to take full advantage of our Affiliated Partners - local organizations with deep histories of work in their communities. As a result, there are significant resources in personnel and relationships readily available for each team. We will also train Care Coordinators on both state and local area resources as part of their orientation. We will take full advantage of websites and printed materials regarding available services. Additionally, we intend to develop am electronic resource "library" to be shared among all Riverside Community Partners BH CP teams, which will be updated and added to over the course of the program, including social services and supports in the areas we serve

c. The Bidder's planned strategies for collaborating with ACOs to recommend Flexible Services on behalf of Engaged Enrollees/following-up on the outcomes of such supports.
In the event that any of the identified services or supports desired by the Enrollee are considered Flexible Supports and require authorization by the Enrollee's ACO, the Care Coordinator will facilitate the process to attain authorization. It is our intent to define a mutually agreed upon process for collaborating on Flexible Support determinations with each of the ACOs with which we will contract. We expect that part of our responsibility will be to provide the rationale for how Flexible Supports recommended by our Care Coordinator would potentially improve the health outcome for the Enrollee. Upon approval, the Care Coordinator will ensure the supports are included in the Enrollee's Person-Centered Care Plan and assist the Enrollee in accessing the services and supports as necessary. The Care Coordinator will follow-up with the Enrollee

periodically to ascertain how the Enrollee is utilizing and experiencing supports and work with the Enrollee to find different supports to better meet his/her needs, as necessary.

Attachment to Section 7.3.C 2.
Proposed Comprehensive Assessment Tool

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Behavioral Health Community Partner Program - Comprehensive Assessment Form

Assessment Meeting Information					
Assessment Started Date:	☐ Face to Face ☐ Telephonic	Location:			
Assessment Completion Date:	☐ Face to Face ☐ Telephonic	Location:			
Staff Completing Assessment:	Others present & relationship to client:				
Critical Information					
Name:	DOB:	Gender:			
Social Security#:	Primary Language: Other Language:	Linguistic/visual accommodation needed:			
Address:	City:	Zip Code:			
Primary Phone:	H ☐ C ☐	2nd Phone:	H☐ C ☐	Email:	
Best time and method to contact Person:					
Visual, hearing or other accommodations requested or required: Y ☐ N ☐ If Yes Explain:					
Marital Status:	Children: Y ☐ N ☐	Ages:	Cohabitating: Y ☐ N ☐		
Mode(s) of Transportation Client Uses to get to appointments: Personal Car : Y ☐ N ☐					
Health Insurance: Y ☐ N ☐	Health Insurance:	Account #:	Policy Holder Name:		
Secondary Health Insurance: Y ☐ N ☐	Health Insurance:	Account #:	Policy Holder Name:		
Emergency Contact(s):					

Collateral Providers					
Primary Care Provider (PCP) and MCO/ACO					
Consent Date		Name & Agency	Phone Number	Address	Notes
	PCP				
	MCO/ACO				
Legal Responsibility for Client (If Applicable)					
Consent Date	Provider Service	Name & Agency	Phone Number	Address	Notes
	Legal Guardian Conservator, Permanent				
	Rogers Guardian				

	Health Care Proxy Information				
	Advance Directives Information				
Behavioral Health Providers					
Consent Date	Provider Service	Name & Agency	Phone Number	Address	Notes
	Emergency Services Provider				
	Therapist				
	Psychiatrist/ Prescriber				
	Psychologist				
	Peer Specialist				
	DMH				
	Day TX				
	Detox/SA TX				
	Day Program				
	Volunteer				
	Other (managed care, clubhouse, etc.):				
Physical Health Providers					
Consent Date	Provider Service	Name & Agency	Phone Number	Address	Notes
	Pharmacy				
	Durable Medical Equipment (DME)/Assistive Technology Provider				
	Assistive Technology or DME Repair Service				
	Previous PCP				
	Dentist				

	Medical Specialist:				
	Medical Specialist:				
	Medical Specialist:				
	Medical Specialist:				
	Home Health Service:				
	VNA:				
	PCA				
Preferred Providers - Hospitals and Emergency Departments					
Consent Date	Preferred Providers	Name & Agency	Phone Number	Address	Notes
	Physical Health Hospital				
	Mental Health Hospital				
	Emergency Room				
Other Support Providers					
Consent Date	Provider Service	Name & Agency	Phone Number	Address	Notes
Family & Friend Support					
	Emergency Contact:				
	Family:				
	Friend:				
	Sponsor:				
	Informal Support:				
State Agency Case Managers/Service Coordinators					
LTSS Providers and Other Supports & Contacts					

Interests and Activities	
Daily Routines:	
Strengths:	
Barriers to Care:	
Activity Area	Description
Employment	
Volunteer projects	
Community programs	
Religious groups / worship	
In home activities	
AA, NA other addiction services	
Therapeutic day program	
Leisure Time	
Physical Activity	
Other:	
Interests & Activities – Preferences, goals:	

Activities and Instrumental Activities of Daily Living –
Are you able to do these activities completely independently? With some assistance? Or only with Assistance?

Activity	Completely Independently	With some assistance	Only with assistance	Comment
Schedule appointments as needed	☐	☐	☐	Comment:
Arrange transportation as needed	☐	☐	☐	Comment:
Pay your monthly bills	☐	☐	☐	Comment:
Move around your home	☐	☐	☐	Comment:
Call for emergency help	☐	☐	☐	Comment:
Prepare and eat meals	☐	☐	☐	Comment:
Do your own laundry	☐	☐	☐	Comment:
Dress yourself	☐	☐	☐	Comment:
Shower or bathe	☐	☐	☐	Comment:

Shop for self	☐	☐	☐	Comment:
Remember and get to appointments on time	☐	☐	☐	Comment:
Maintain good hygiene/wear clean clothing	☐	☐	☐	Comment:

Current Living Situation				
Your living situation	Own ☐ Rent ☐	Describe:	How long have you lived here?	
Do you live alone?	Y ☐ N ☐	If no, who else do you live with?		
Supported Housing?	Y ☐ N ☐	If yes, which agency?		
Group Residence?	Y ☐ N ☐	If yes, which agency?		
Is Housing Stable?	Y ☐ N ☐	Describe:		
Currently Homeless?	Y ☐ N ☐	If yes, for how long?	If yes, where are you staying?	
Cause of homelessness:				
Do you have a housing subsidy?	Y ☐ N ☐	If yes, describe status:		
Are you currently on a waiting list?	Y ☐ N ☐	If yes, describe status & location :		
Any concerns about the safety of your home?				
Housing Situation – Preferences, goals:				

Financial Resources		
Source	Monthly amount	Other information
Employment		
SSDI		
SSI		
Retirement / Pension		
Family / Trust		
Child Support		
SNAP Benefits / DTA		
Fuel Assistance		
Other:		
Do you have family or friends who contribute to your financial support? ☐ No ☐ Yes / Comments:		
How would you describe your current financial situation? ☐ Comfortable/ living within means ☐ Occasional struggle with finances ☐ Often struggles with finances ☐ Financial struggles are a major source of stress Comments:		
Do you have a rep payee?	Y ☐ N ☐	If yes, name:
Do you want a rep payee?	Y ☐ N ☐	If yes, name:

Do you have enough food to eat?	Y ☐ N ☐	Comment:
Where can you get emergency food if needed? (ex: food pantry)		Comment:
Financial Resources – Preferences, goals:		

Education

Brief description of educational history – include highest grade, degree completed and dates:

Educational Level	Years	School	Completed Y/N	Additional Information
High School:				
GED:				
College:				
Additional:				
Additional:				

Educational Interests/Skills:
Do you want to pursue additional education? Y ☐ N ☐ Uncertain ☐ Comment:

History of Learning Difficulties: ☐ None Reported
Performance / Behavioral Problems related to: ☐ Mental Health (MH) ☐ Substance Use (SU)
☐ Learning Disability: ☐ Past ☐ Current Type(s): _____
☐ Developmental Disability (DD): Type(s): _____ Mild problems: ☐ Moderate/Severe Problems: ☐
Other/Comments (include sources of information):

Person's Preferred Learning Style(s): ☐ Visual/spatial ☐ Auditory/Musical ☐ Verbal/writing ☐ Physical

Barriers to Learning: ☐ None Reported
☐ Attention Difficulties ☐ Cognitive Difficulties ☐ English is Second Language ☐ Hearing Impaired
☐ Reading Difficulties ☐ Writing Difficulties ☐ Visually Impaired
☐ Other/Comments:

Education Resources – Preferences, goals:

Employment

Brief description of employment history:

Do you currently use an employment support program?	Y ☐ N ☐	If yes, contact name:
Do you want employment support?	Y ☐ N ☐	Comment:

Dates of Employment	Position	Company	Skills gained/other information

☐ Current Employed: (Check all that apply ☐ Not in Labor Force: (Check all that apply)

☐ Full Time (32 hours or more per week) ☐ Part-time (< 32 hours per week) ☐ Volunteer/Intern ☐ Supported Employment ☐ Transitional Employment Program ☐ Other:	Date Last Worked: ☐ Currently Seeking Employment ☐ Disabled ☐ Retired ☐ Homemaker ☐ Student ☐ Other:
Are you currently satisfied with your job? ☐ No ☐ Yes ☐ N/A Comment:	Is your job in jeopardy? ☐ No ☐ Yes ☐ N/A Comment:

Reason(s) for Leaving Jobs in Last 5 years: ☐ NA

☐ Did not like work hours ☐ Did not like working conditions ☐ Did not like job duties ☐ Did not get along with co-workers ☐ Did not get along with boss/supervisor ☐ Pay too low	☐ Mental Health problems ☐ Medical problems ☐ Substance use problems ☐ Maternity Leave ☐ Baby sitter/child care problems ☐ Lacked transportation	☐ Temporary Employment ☐ Terminated ☐ Laid off ☐ Other:

Employment Resources – Preferences, goals:

Military Service History

Military Experience: ☐ NA Combat Experience: ☐ Yes ☐ No

Branch(es): ☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ Coast Guard ☐ National Guard ☐ Other:

Dates of Service: - Type of Discharge ☐ Honorable ☐ Conditional / ☐ Dishonorable

Unit: / Major Tasks of Unit:

Metals/Accommodations:

Military – Preferences, goals, comments:

Physical Health Status

General state of person's physical health per self-report:

Physical Health Diagnosis	Date Diagnosed	Treating Provider
		Name:
		Name:
		Name:
		Name:
		Name:
		Name:

Check any of these health conditions you have: ☐ Arthritis ☐ Asthma ☐ Heart Disease ☐ Congestive Heart Failure	☐ Cancer ☐ Diabetes Type I ☐ Diabetes Type II ☐ Chronic Heartburn/GERD ☐ High Cholesterol ☐ High Blood Pressure	☐ Heart Bypass Surgery ☐ Irritable Bowel Disease ☐ Lower Back or Neck Pain ☐ Heart Attack ☐ Other (please list): ☐ Other (please list):

Do you want to know more about weight management resources? Y ☐ N ☐ Comment:

If you are a smoker, are you interested in smoking cessation programs? Y ☐ N ☐ Comment:

Do you use any assistive technology/devices?	Y ☐ N ☐ If yes, Describe Types:
Do you use any devices to assist with mobility?	Y ☐ N ☐ If yes, Describe Types:
Have you fallen in the last six months? * Y ☐ N ☐ Comment: If Yes, How many times? * Comment: Have any of your falls required medical attention? * Comment: * Additional Fall Risk screening may be completed by BHCP RN using the Powell and Myers' Activities-specific Balance Confidence Scale	

Behavioral Health Status		
General state of person's behavioral health per self-report:		
Behavioral Health Diagnosis	Date Diagnosed	Treating Provider
		Name:
		Name:
		Name:
History of harm to self? Y ☐ N ☐ Comment:		
History of harm to others? Y ☐ N ☐ Comment:		
Allergies: ☐ No Known	Food:	Medication: Environmental:
Medications you've tried before that you feel were not effective:		
Additional Comments:		

Medication Status				
Current Medication Name	**Dose**	**Frequency**	**Purpose**	**Side Effects & Benefits**
Allergies: ☐ None Known	Food:	Medication:	Environmental:	
How do you get your daily/monthly medications:	Comment:			
Do you have any assistance with your medication administration	Y☐ N☐	Comment:		

Additional Comments:

Modified Morisky Scale			
	Question	Motivation	Knowledge
1	Do you ever forget to take their behavioral health medicine?	☐ Yes (0) ☐ No (1)	
2.	Are you careless at times about taking your medicine	☐ Yes (0) ☐ No (1)	
3.	When you feel better do you sometimes stop taking your medications?		☐ Yes (0) ☐ No (1)
4.	Sometimes if you feel worse when you take your medicine, do you stop taking it?		☐ Yes (0) ☐ No (1)
5.	Do you know the long-term benefit of taking your medicine as told to you by your doctor or pharmacist?		☐ Yes (1) ☐ No (0)
6.	Sometime do you forget to refill your prescription medicine on time?	☐ Yes (0) ☐ No (1)	
	Total Score:	Total: 0-1= Low Motivation 2-3 = High Motivation	Total: 0-1= Low Knowledge 2-3 = High Knowledge

Behavioral and Physical Health Service Use History			
Type of Service (Med/Psych Hospitalization, detox, SA TX, Day TX, Outpatient)	Dates of Service	Reason for Treatment	Name of Provider/Agency

Trauma History Status	
Does person report a history of trauma? ☐ No ☐ Yes	
☐ Physical Abuse	Comment:
☐ Verbal/Emotional Abuse	Comment:
☐ Sexual Abuse/Molestation	Comment:
☐ Financial Abuse	Comment:
☐ Domestic Violence/Abuse	Comment:
☐ Elder Abuse	Comment:

☐ Physical neglect	Comment:			
☐ Military Trauma	Comment:			
☐ Witness to Abuse/Violence	Comment:			
☐ Other:	Comment:			
☐ Other:	Comment:			
Current Involvement by: ☐ None Reported	☐ DCF	☐ Elder Affairs	☐ DPPC	☐ Other:
Additional Reporting Required: Y ☐ N ☐	Person Responsible for reporting:	Comment:		

Substance Use Status		
Have you ever felt you should cut down on your drinking or drug use?	Y ☐ N ☐	Comment:
Have people annoyed by you criticizing or complaining about your drinking or drug use?	Y ☐ N ☐	Comment:
Have you ever felt bad or guilty about your drinking or drug use?	Y ☐ N ☐	Comment:
Have you ever had a drink or drug in the morning to steady your nerves or get rid of a hangover?	Y ☐ N ☐	Comment:
Are you currently in recovery/sober? If yes, for how long?	Y ☐ N ☐	Comment:
Do you want support in reducing your use of alcohol, non-prescribed medications or other drugs? Y ☐ N ☐ Comment:		
Do you have access to NARCAN? Y ☐ N ☐ N/A ☐Comment:		
Do you want access to NARCAN? Y ☐ N ☐ N/A ☐Comment:		

Have you ever used:	**Age of First Use**	**Date of Most Recent Use**	**Frequency**	**Amount**	**Method of Use (as applicable)**
☐ Alcohol			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ Amphetamines/ Stimulants			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ Barbiturates/ Sedatives			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ Caffeine			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week		☐ Oral ☐ Smoked ☐ Inhaled

			☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Injected ☐ Other:
☐ Crack/Cocaine			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ Hallucinogens			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ Heroin/Opiates			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ Inhalants			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ Marijuana			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ Nicotine			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ Other:			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:

Substance Use Treatment: (Check all that apply) ☐ None	
☐ Outpatient ☐ Residential ☐ Inpatient/Detox ☐ Court Mandated ☐ Other Treatment:	Comment: Comment: Comment: Comment: Comment:

Additional Information:

Criminal Justice Involvement			
Are you currently on probation or on parole?:			
Describe any history of arrests or incarcerations (when, reason, outcome, etc.)			
Probation Officer:	Y ☐ N ☐	Name:	Contact:
Parole Officer:	Y ☐ N ☐	Name:	Contact:
Does individual want a copy of their CORI or SORI:	Y ☐ N ☐	Additional Information:	

Risk History Status							
Danger to Self				Danger to Others			
	Current	Past	Comment		Current	Past	Comment
Suicidal Ideation	☐	☐		Ideation	☐	☐	
Plan	☐	☐		Plan	☐	☐	
Intent	☐	☐		Intent	☐	☐	
Means	☐	☐		Means	☐	☐	
Prior Attempts	☐	☐		Identifiable Victim	☐	☐	
Self-injurious behavior	☐	☐		Other	☐	☐	

Family Medical and Behavioral Health History		
Family Medical History		
Person/Relationship	Comment on history	Reported By
Family Behavioral Health History		
Person/Relationship	Comment on history	Reported By

Areas individual would like to focus on:

Check	Need Areas	Immediate Need?	Information about current situation & Quote from person served
☐	Housing or Food	☐	
☐	Mental Health	☐	
☐	Transportation	☐	
☐	Physical Health and Wellness	☐	
☐	Employment/Education	☐	
☐	Money	☐	
☐	Benefits & Community Resources	☐	
☐	ADL Supports	☐	
☐	Legal/Documentation Support	☐	
☐	Other:	☐	

Current and Relevant Acute Plans for Addressing Medical and Behavioral Health Conditions	
Acute Medical Need	Current Plan
Acute Behavioral Health Need	Current Plan
Other Immediate Needs	Current Plan

Signatures

Enrollee Name:_____

Enrollee Signature:_____ Date: _____

Enrollee Proxy Signature (if applicable): _____ Date: _____

Guardian Name (if Applicable):_____

Guardian Signature:_____ Date: _____

CP Nurse Name:_____

CP Nurse Signature:_____ Date: _____

Care Team Member Conducting Assessment Name:_____ Care Team Member Signature:_____ Date: _____
Care Team Member Conducting Assessment Name:_____ Care Team Member Signature:_____ Date: _____

Section 7.3.D. Innovative Technologies

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Section 7.3 Initial DSRIP Participation Plan

D. Innovative technologies for service delivery (not to exceed 1 page)

The Bidder shall describe innovative technological tools it currently has and how it will use these tools for the delivery of CP Supports. Specifically, the Bidder shall describe its planned uses of technological tools, such as care management or coordination software, telehealth tools, tablets, smartphones, automatic pill dispenser/electronic medication reminder systems, and other adaptive technologies.

Riverside Community Partners expects to leverage technology to the full extent possible to enhance the effectiveness and efficiency of our BH CP services. This will include use of care management and care coordination software included in the Netsmart Evolv electronic health record that Riverside Community Care and one Affiliated Partner currently uses, which will be designed to enable Riverside to collect and disseminate data across all partners. Additionally, our Affiliated Partners who are also members of Community Care Cooperative (C3) will use Identifi Care, a care coordination application embedded within C3's overall electronic record, and will electronically transmit their required data to Riverside's system.

We will also seek to employ technologies that directly enhance the quality of our communication with and person-centered experience of Enrollees. For example, we recognize that for some Enrollees who do not speak English, language might be a barrier when, despite our best efforts, we do not have an available staff who speaks their language. Riverside has committed to be an early adopter of a new technology, a Smart Earpiece Language Translator from Waverly Labs. This technology, soon to be released, is a wearable language translator that would be worn by the staff person and the Enrollee to aid in direct communication without need for another individual to serve as a translator. We have purchased two sets, and if utilizing it is helpful, we will purchase additional sets to share among programs as needed.

We will also explore using tele-behavioral health technology within the BH CP program. Riverside was awarded a grant from the Massachusetts Health Policy Commission to implement a tele-behavioral health pilot with homebound elders. We are working with an experienced tele-psychiatry company and using laptops and a Skype type program and will leverage our learning from this pilot to develop options for applying tele-behavioral health to our CP work. One of our Affiliated Partners has also been using tele-behavioral health and will assist in developing its application to BH CP. We will also use video-conferencing for some staff trainings and psycho-education and health promotion trainings for Enrollees.

We also intend to use Shared Decision Making, an interactive tool and emerging best practice developed by Patricia Deegan, Ph.D. that is available on line from SAMHSA. This pairs communication and decision making tools to assist individuals with behavioral health conditions to consider treatment options in conjunction with their own preferences, goals, cultural beliefs and values and to develop a report that can be shared with their prescriber. Riverside was an early pilot site for this tool years ago, and we understand its value in assisting people to make treatment decisions they are more likely to feel ownership of and follow the recommended medication and other treatment regimens. We will explore ways to make this online tool available to Enrollees who may or may not have their own access to computers. We intend to continue seeking and exploring additional innovative technologies as our BH CP program becomes fully operationalized and develops over the next few years.

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Section 7.3.E. Personnel and Staffing

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Section 7.3 Initial DSRIP Participation Plan

E. Personnel and staffing (not to exceed 5 pages, excluding attachments)
The Bidder shall provide its proposed staffing plan to perform the Contractor Responsibilities set forth in Attachment A, including fully implementing the required scope of CP Supports as well as the administrative aspects of the Contract. The Bidder shall provide:
1. An organizational chart (as an attachment) that identifies personnel, senior managers, and other staff by title to be assigned to accomplish the Contractor Responsibilities described in Attachment A;

The Riverside Community Partner Organizational Chart is provided below as an **Attachment to this subsection (7.3.E.).**

2. A sample staffing model for the number of Engaged Enrollees in each Service Area as indicated by the Bidder in Attachment D, including the number of full-time equivalent (FTEs) for supervision, administration, and Care Management and Care Coordination positions;
Riverside's core staffing model is based on teams organized to serve 400 MassHealth Enrollees. Each team includes a full-time Clinical Care Manager, two full time Nurse Care Managers (an RN and an LPN), and eight Care Coordinators. Each team will also have access to a Medical Director to provide leadership, oversight and supervision as needed. This model assumes a caseload of 50 MassHealth Enrollees per Care Coordinator, with significant support provided by the Clinical Care Manager and the Nurse Care Managers. This model will be replicated multiple times by Riverside and our six Affiliated Partners to fulfill our planned coverage of a total of 3,800 eligible MassHealth members across our proposed Service Areas. (We will scale this model up as the referrals are received. We will monitor staff capacity as assignments are received and consider temporary additional staff, particularly registered nurses, and LPNs if necessary). Teams will be located throughout our Service Areas, but none will be required to only serve a single Service Area. Instead, each team, while primarily drawing from the Service Area in which it is physically located, will also be able to provide BH CP services to Enrollees in abutting areas, allowing us to create maximum flexibility to respond to currently unknown enrollment patterns. Since much of the BH CP work will be conducted either electronically, telephonically, or through mobile staff outreach, we believe our plan will provide the optimal means to ensure all geographies within our Service Areas are well covered by Riverside and our Affiliated Partners.

The Clinical Care Managers will be either independently licensed BH clinicians, currently defined as LICSWs or RNs. For some teams, this position will also function as the Team Leader, providing direct supervision to the rest of the team members. Every team will have two Nurse Care Managers, at least one of which will be an RN and the second an LPN. . Care Coordinators will largely be Bachelors level staff who are trained in accordance with the requirements specified in Section 2.4.c of this RFR. We plan to include a Recovery Specialist/Person with Lived Experience among the eight core staff, believing this will be an invaluable resource to the people we serve.

Riverside will directly operate up to three full teams and our Affiliated Partners will develop local teams to manage members in their own or a nearby geographic area. In many instances, Riverside will directly staff and operate a team and one of our Affiliated Partners will also serve the same geography. Not all teams will include the full eight Care Coordinators where Riverside or an Affiliated Partner chooses to operate with a smaller team, which may be an extension of an existing care management service. These smaller teams will still meet all requirements set forth in the RFR, including the staffing requirements for the LICSW and RN.

Supervision is built into each team's own structure, typically by the Clinical Care Manager/Team Leader. In addition, all teams will be coordinated and supported by the full-time Director of Riverside Community Partners, Nora Kenney-Houser, LICSW. She will be further supported and supervised by a member of Riverside Community Care's senior management, Jason Moscato, RN, MS, LMHC who will provide additional oversight to the BH CP program. The Director will have two full-time Administrative Assistants to provide additional support for the program and for her oversight and monitoring functions.

3. A description of the Bidder's recruitment plans, including timelines to recruit staff for any personnel positions not currently filled, and job descriptions and qualifications for each personnel position (job descriptions shall be submitted as attachments). The job descriptions shall contain information regarding education, background, qualifications, credentials, and relevant recent work experience;

Riverside already employs the person who will become the Riverside Community Partners Director. Nora Kenny-Houser, LICSW has been managing similar services for Riverside for several years (including overseeing our work on Here for You). She will begin to assume responsibilities for the BH CP program early in the preparation budget period to assist in setting up program operations, including hiring Riverside's team leadership. Specifically, she will hire the Riverside team Clinical Care Managers/Team Leaders and will assist them in hiring the additional team members.

Riverside and each of our Affiliated Partners will recruit for our respective teams utilizing our own proven strategies for recruitment. We believe local recruitment results in the most effective path for hiring and for finding employees who know and understand the local community and reflect the culture and languages spoken in the area. We expect to enhance local recruitment by pooling resources when we find candidates who could benefit one of our Affiliates because they live in a particular community or speak a particular language.

We will phase in recruiting, beginning in January and continuing throughout February and March of 2018 for all unfilled positions. We intend to hire core staff, including a roster of Care Coordinators for each team, ahead of the June 1, 2018 start date (detailed in the Budget Narrative) to allow Riverside and our Affiliated Partners to train staff in advance of referrals. Additional staff will be added and trained as the program continues to ramp up. As noted above, we will monitor staff capacity as we receive assignments and consider adding temporary staff such as registered nurses, as necessary.

Position descriptions for the core staffing, Clinical Care Manager, Care Coordinator and Nurse Care Manager are included as an attachment to this proposal, as is the description for the Riverside Community Partners Director. The qualifications for each position are included in the descriptions and are in compliance with requirements where specified in the Request for Responses and Attachment A Model Contract.

Riverside has been extraordinarily successful in recruiting well qualified employees across all our programs. Our vacancy rate runs well below 10%. We will benefit from the expertize of our Talent Acquisition Department to recruit for BH CP positions, including assisting our Affiliated Partners by sharing resumes of applicants who come to us from communities where they are trying to ramp up. We will post jobs and advertise through OpenHire, Zip Recruiter, College and University sites, utilize college career fairs, career centers, and recruitment days at key sites to identify potential hires. We will also source passive candidates via LinkedIn, CareerBuilder, SchoolSpring, Indeed, Twitter, Facebook, college resume books, and other creative avenues. Many of our employees come through internship programs and we will identify any qualified candidates who may come from this source as well. Finally, we expect that some BH CP applicants may be current employees of Riverside or our Affiliated Partners who are interested in joining this new venture**.**

Job descriptions are provided below as **Attachments to this subsection (7.3.E.3).**

4. A description of how the Bidder will recruit and hire staff from the cultural and linguistic communities they intend to serve;

Many of the communities we propose to serve have residents who speak Spanish, Portuguese, Haitian Creole, French, and other languages. Riverside and our Affiliates have deep relationships with the local communities and already serve them. We have employees who live locally and who reflect the ethnic and cultural diversity of the local areas. Our established connections with the communities we serve will help us attract staff for the BH CP program, including but not limited to Care Coordinators and people with lived experience of behavioral health challenges. As stated in the RFR, it will be critical to "…recruit, employ and manage appropriate and qualified personnel, including supervisory staff, with diverse cultural and linguistic backgrounds…"

We understand that language capacity is a core component of providing appropriate and competent care and care management. Riverside, working with our Affiliated Partners, serves a very diverse population and we are all skilled at identifying and meeting the linguistic needs of the populations served, including those who are deaf and hard of hearing and who have low health literacy. In some situations one of our Affiliated Partners will be particularly well-equipped to meet linguistic needs. We will periodically assess the match between population needs and Riverside Affiliated Partner's capacity and implement initiatives to ensure we are maximizing the benefit of our range of partners.

In addition, we will recruit through diverse student organizations such as the Latino Leadership Initiative at Boston College, the Gay Straight Alliance, Black Student Unions, ALANA – the African American, Latina, Asian, and Native American Nursing Group, and other multicultural clubs. We also partner with community organizations such as the Haitian American Society

Club, Mass Alliance for Portuguese Speakers, the Massachusetts Rehabilitation Commission, Puerto Rican Cultural Center, Casa Latina, and the Bilingual Veteran's Outreach Centers of Massachusetts, etc.

There are media sources that are targeted at specific communities such as Rainbow Times, Haitian Times, LinkedIn groups, Facebook groups, etc. We will consult Riverside's Diversity and Inclusion Manager as well as those with similar positions among our Affiliated Partners. We also may utilize referral bonuses, especially for specific, hard to fill positions.

Riverside Community Partners commits to the following principles:

- We will advance and sustain organizational governance and leadership that promotes Culturally and Linguistically Appropriate Services and health equity through policy, practice and allocated resources
- We will recruit, promote, and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in our service area
- We will educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis
- We will seek to identify specific population groups through surveys and data analysis and work to meet their needs

5. Proposed training, orientation plans and modules for staff; and

In addition to each of our Affiliates providing orientation and training focused on their own organization, we will provide overarching training – taking advantage of the scale of Riverside Affiliated Partners which will include as many as 75 Care Coordinators and multiple Care Coordinators and nurses, training will include:

<u>General Orientation for Each Affiliated Partner</u>

Organizational mission statement, policy manuals relevant to job, phone numbers of key services and supports, written orientation to specific related programs, HIPAA regulations, transporting records, quality management and compliance information, human rights policies, incident reporting procedures, dress policy, human resources information and requirements, confidentiality, code of ethics, computer orientation, keys, ordering supplies, fraud and abuse training.

<u>Specific Orientation for all Employees Working for Riverside Community Partners</u>

Program mission, program overview, job description, supervisor's expectations, setting schedule, training in specific software, overview of services provided by program, program forms, standard consumer record documentation, introductions to key personnel, building tour, training and certification as necessary, safety and de-escalation techniques, health and safety, crisis management.

<u>Training (Required Core Topics to be Determined)</u>

Note: These trainings will be offered in various formats including live presentations, as well as video conferencing and webinars. Many of these trainings are available and have been field tested. Several are in development. SAMSHA and other sources are also utilized. We will

ensure orientation and training includes all mandated trainings delineated in Section 2.4.C of the Model Contract in Attachment A of the RFR.

Engaging people served by phone; engaging collateral contacts in the care of the person served; safe driving of consumers; self-determination, recovery, resiliency and wellness; phone screening for the first home visit; motivational interviewing; psychopharmacology; the experience of hearing voices; best practices in suicide assessment; working with people affected by domestic violence; ABCs of sustainable time management; burnout, compassion, fatigue and the art of self-healing; human trafficking; autism primer; substance use and co-occuring mental health disorders; mental health and substance use and probation; the nuts and bolts of SSI, SSDI, PASS, and other State benefits; an introduction to transgender individuals, serving underserved populations; lessons in resilience; age related brain disease; supporting recovery in acute care and emergency settings; hospital diversion; critical skills for activating self-management; integrating primary care and wellness into behavioral health; chronic pain management and SUDs; understanding harm reduction.

6. Description of staff retention strategy

Riverside has identified employee retention as a critical factor in the success of our organization. As a result, we offer our employees full service career consulting with the goal of keeping employees within our organization. With the advent of Riverside Community Partners, this model can be utilized to help keep them within our network. We have found that career fairs for our interns helps keep valuable new graduates in our system and, again can expand this to our broader network.

Our goal is to utilize the best practices we develop over time, offer training across the network, and build the kind of positive workplace and comradery that helps engage staff. We have learned that an engaged workforce leads to better morale, pride in one's work, higher quality care and employee longevity. One important factor in an engaged workforce is the quality of the supervision and management staff experience, and in particular, the success of managers and supervisors in communicating with each staff in a way that enables that staff to feel valued and included. Therefore, the training, supervision and support of program managers throughout the Riverside Community Partner program will be an area of focus for us. This will be accomplished through several means, including the internal resources and practices of each of our Affiliated Partners, the support and consultation of the Riverside Community Partners Director, and through shared meetings and trainings throughout the course of the program. In addition, Riverside and our Affiliated Partners will encourage staff to directly take advantage of our training programs.

Finally, to ensure we understand what is working and what is not, we will survey staff and conduct occasional exit interviews.

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Section 7.3.E. Attachment 1

Organizational Chart
Riverside Executive Leadership and Community Partner Program Staff

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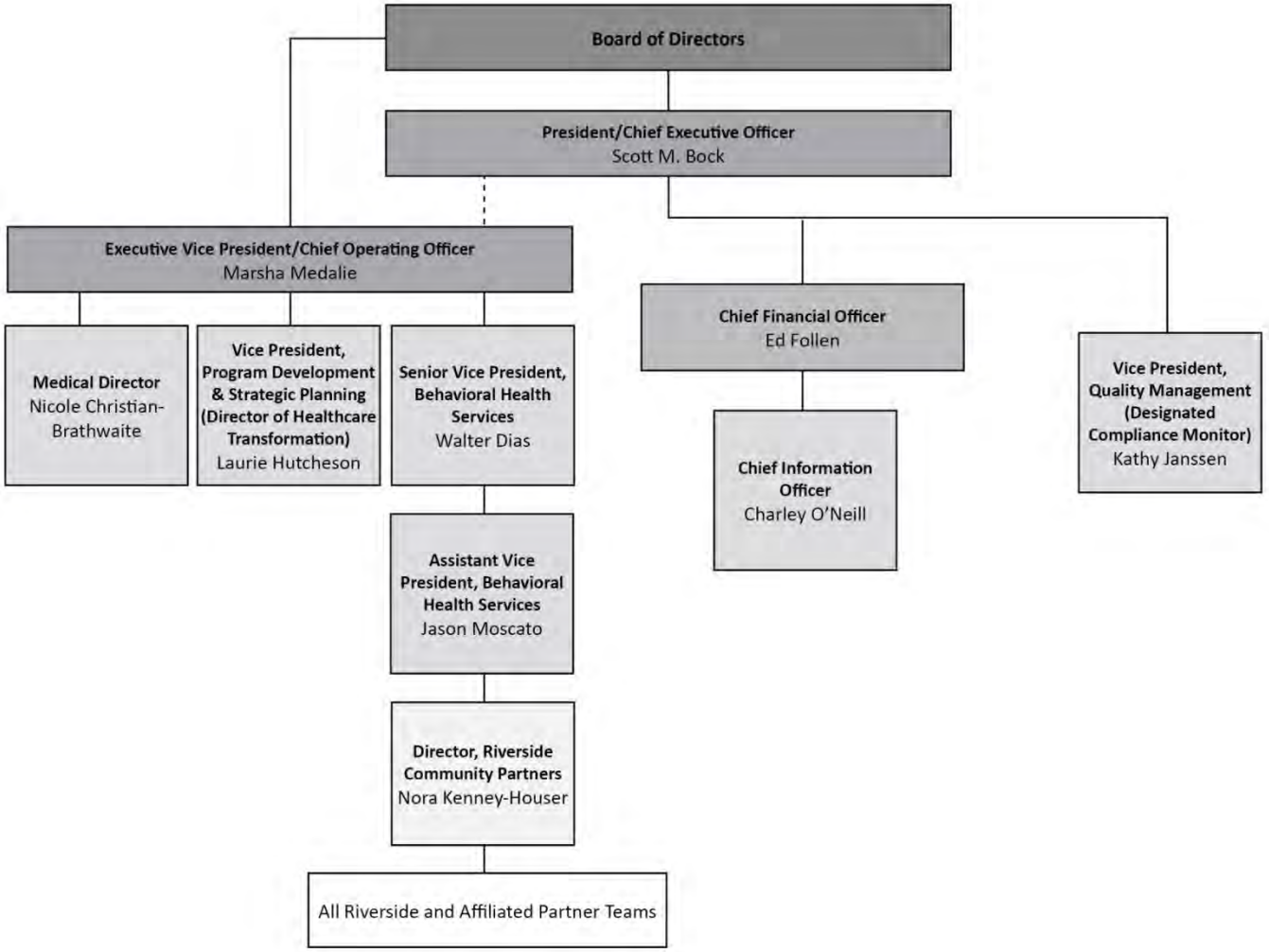
7.3.E.1 Riverside Executive Leadership and BHCP Staffing



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Section 7.3.E. Attachment 2.

Job Descriptions: Riverside and Community Partner Program Staff

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RIVERSIDE COMMUNITY CARE

Job Description

Title: Program Director

Reports to: Assistant Vice President for Behavioral Health Services

Program: Riverside Community Partners

Division: Behavioral Health Services

Job Titles Reporting to this Position: Riverside Clinical Care Manager/Team Leaders, Administrative Assistant, others as assigned

Position Summary: The Program Director is responsible for direct supervision of Riverside's Behavioral Health Community Partner (BH CP) teams, for oversight of the Riverside Community Partners overall program and for serving as a primary contact with ACOs/MCOs and EOHHS regarding the BH CP program. The Director collaborates with Riverside's Affiliated Partner teams to share resources, develop best practices, ensure compliance with all BH CP contract policies and procedures and receive and transmit required reports. The Director performs these duties with support from the Associated Vice President (AVP) for Behavioral Health Services, the Vice President (VP) for Quality Management/Community Partner Program Quality Manager and Compliance Monitor or designee, the Medical Director, the VP for Program Development and Strategic Planning/Community Partners Director for Healthcare Transformation , and assigned Administration & Finance Department personnel.

Essential Duties and Responsibilities:

A. BH CP Program Management and Oversight

- Accepts referrals of Assigned Enrollees from ACOs/MCOs and or EOHHS and distributes referral to appropriate BH CP teams according to geography, preexisting relationship, Enrollee preference and team capacity
- Tracks all required elements of service delivery and documentation as conducted by and reported from all BH CP teams, and prepares and submits required reports to EOHHS pursuant to Community Partner contract requirements and in support of submission of claims for payment
- Develops any new policies and procedures related to Behavioral Health Community Partner Program implementation that must be developed pursuant to the Community Partner contract and obtains EOHHS approval, as directed, for such policies and procedures before implementation. Ensures all approved policies and procedures are disseminated to all Community Partner Program staff, that training relating to implementation is provided timely, as necessary, and oversight is provided to ensure ongoing understanding of and compliance with all.

- Develops, maintains and routinely updates electronic directory of community based services and supports that are resources for the Community Partner Program in all the service areas that the Riverside Community Partner program covers.
- In conjunction with Quality Management and in collaboration with Affiliated Partners, monitors through reports, record sampling, meetings and other means all BH CP teams to ensure performance of BH CP activities are being delivered in a high quality, person centered manner in adherence with program policies and procedures, and that they meet all contract requirements including documentation of requisite signatures of Care Team and Enrollee on key documents such as the Person-centered Care Plan. Brings any issues to the attention of the relevant BH CP Team Leader and if not resolved in a timely manner, notifies the AVP and the Affiliated Partner's designated leader for assistance in correcting the issue
- Leads collaboration of all Team Leaders in the development and dissemination of best practices, resource directories, staff training curricula, Enrollee health and psycho-education materials or trainings, and other program enhancement initiatives
- Leads the development of staff training curricula and ensures all Team Leaders and ensuring team staff receives required orientation upon hire and program specific trainings at orientation and refreshers annually.
- Collaborates with the Vice President of QM and the Quality Committee as appropriate to operationalize annual Quality Initiatives across all teams
- Collaborates as needed with QM and Medical Director regarding critical incident and grievance resolution and reporting
- Responds to requests for ad hoc reports and submission of enrollee records and related documents as may be requested by EOHSS.

B. Supervision of Riverside Community Care BH CP Teams

- Screens, hires, takes necessary disciplinary action and /or terminates as necessary Riverside's BH CP Clinical Care Manager/Team Leaders and other BH CP staff as needed in collaboration with the AVP and Human Resources
- Provides regular supervision and written performance reviews to supervisees accordance with Riverside policies
- Ensures that Riverside Team Leaders fulfill their role in supervising team staff so that all assigned Enrollees receive needed and appropriate services, and that teams provide quality care in compliance with all contract requirements, Riverside policies and procedures and applicable laws and regulations.
- Provides ongoing support to the professional development of supervisees, including but not limited to training and skills development.

C. Administrative

- Ensures teams complete all clinical documentation, including Assessments, Care Plans, progress notes, updates, incident reports, forms, etc. in a complete and timely manner and in compliance with organization and relevant state protocols.

- Ensures teams complete all administrative documentation, including program statistics, reporting, payroll, etc. in a complete, accurate and timely manner in compliance with organization and relevant state or payer requirements**.**
- Compiles and transmits all required all requisite Community Partner reports in a timely and accurate manner.
- Participates in Quality Committee, Governance Committee and/or other committees as may be assigned.
- Participates in the development of Quality Initiatives, a BH CP resource directory and other initiatives as needed and ensures all teams conduct required surveys.
- Assumes additional responsibility consistent with program needs and role, as defined in consultation with the AVP.

General Responsibilities

- Ensures compliance with all mandated reporting requirements and regulations (i.e. DCF, DMH, DPPC, Elder Protective Services)
- Reads and follows procedures as detailed in Riverside and program policies and procedures
- Attends and utilizes supervision meetings. Brings issues of concern and/or importance to supervisor for consultation
- Maintains a professional work environment with attention to persons served and staff health and safety by maintaining protocols, alerting management to unsafe conditions, etc.
- Attends all required trainings and administrative meetings
- Other duties as may be assigned

Non –Essential Duties & Responsibilities

- There are no non-essential duties at this time.

Qualifications:

- Masters Degree in a Behavioral health field with Massachusetts licensure at the independent level of practice
- Experience working with people with serious mental illness and substance use disorders and with care management
- Minimum two years supervisory and program management experience
- Familiar with and embraces person-centered planning philosophy and motivational interviewing
- Ability to use a computer for word processing, EHR and email/Outlook Calendar, and the Internet for resource searches and assisting clients with online surveys and using online decision-making tools

Physical & Mental Requirements:
Must have the physical and cognitive abilities and knowledge base to:

- Respond and work with consumers, staff, managers and external parties in a professional, respectful, and sensitive manner.
- Safely perform job functions with or without the aid of mechanical devices.
- Comprehend and carry out policies and procedures using specific instructions and accepted practices.
- Assess complex situations, collaborate and integrate different viewpoints and use good judgment when dealing with others.
- Communicate verbally and in writing in language that can be readily understood by the majority of the program's clients, staff and funders.
- Effectively perform job responsibilities in a high stress environment.
- Regular access to reliable transportation is required in order to attend required trainings, meetings and/or fulfill other responsibilities of this role.

Training Requirements:

- HIV/Infection Control
- Hepatitis B Orientation & Training
- Safety/De-escalation training
- Shared Decision-making (refresher if already trained)
- Training sufficient to maintain licensure
- Community Partners Program specific initial orientation and refresher trainings annually on topics including, but not limited to the following:

    a. Cultural competency;

    b. Accessibility and accommodations;

    c. Independent living and recovery principles;

    d. MassHealth State Plan LTSS and eligibility criteria;

    e. Motivational interviewing (refresher if already trained);

    f. Trauma informed care;

    g. Conflict of interests, including but not limited to those described in **Section 2.4.F**, and the Riverside Community Partner program's mitigation strategy for conflicts of interest;

    h. Health and wellness principles;

    i. Person-Centered Treatment Planning processes, using curriculum approved by EOHHS; and

j. Other trainings as further directed by EOHHS.

- Trainings, community forums, learning collaborative and other meetings and events related to the Riverside Community Partners Program's performance under the Community Partner Contract, as may be requested by EOHHS.

My signature below indicates that I have read and understand the content of this job description.

_____ _____

Employee Signature (Date) Immediate Supervisor Signature (Date)

Approval Date:	Senior Manager Initials:_____
Approval Date:	Human Resources Initials:_____
Revised Date:	
Revised Date:	
Program Code:	CPC Code:
Job Code:	WC Code:

RIVERSIDE COMMUNITY CARE

Job Description

Title: Clinical Care Manager/ Team Leader

Reports to: Riverside Community Partners Director

Program: Riverside Community Partners Team

Division: Behavioral Health Services

Job Titles Reporting to this Position: Care Coordinators, Nurse Care Manager, others as assigned

Position Summary: The Clinical Care Manager/Team Leader serves as the manager of a Behavioral Health Community Partners (BH CP) team, providing direct clinical care management services to enrolled clients, hiring and supervising Care Coordinators and nursing staff and overseeing the operations of all care management and care coordination activities within the team. The position ensures that team members are properly trained and are providing person-centered support to Enrollees in compliance with all contractual and Riverside requirements. The position provides both clinical and operational supervision to all team members and serves as the designated point of contact for referrals to the team.

Essential Duties and Responsibilities:

A. Direct Service Provision

- Serves as Clinical Care Manager for Enrollees referred to the team, participating in the Assessment, Care Planning and ongoing BH CP service provision as specified in program protocols and policies
- Collaborates with the Registered Nurse Care Manager in review of comprehensive assessments of all enrollees and conducts final review and approval of comprehensive assessments of all Enrollees assigned to the team
- Assumes primary responsibility for aspects of Enrollees care when master's level staff intervention is needed and ensures consultation with Medical Director as needed on complex cases
- In conjunction with other Clinical Care Managers/Team Leaders and others, develops and provides psycho-education and/or health promotion trainings for Enrollees

B. Supervision/Consultation

- In conjunction with Program Director, screens, hires, takes necessary disciplinary action and /or terminates program staff in collaboration with the Director and Human Resources.
- Provides regular supervision and written performance reviews to all team members in accordance with Riverside policies, ensuring that staff's assigned Enrollees are receiving needed and appropriate services, and that staff conduct themselves in a professional,

person-centered and respectful manner with Enrollees, families, Care Team members, collaborators, payers, regulators and others.

- Monitors and ensures quality of care in service provision, risk assessment, collaboration and documentation by all staff and that all Care Team processes are conducted in compliance with and adherence to all BH CP policies and procedures.
- Provides ongoing support to the professional development of supervisees, including but not limited to training and skills development.
- Participates in multi-disciplinary team meetings, utilization review and program planning.
- Assists Care Coordinators, as necessary, to obtain and utilize accommodations, such as translator services, as necessary, to support outreach, engagement and ongoing care coordination activities with Enrollees with disabilities or language needs that warrant special accommodations for communicaton.
- Creates and updates a directory of and ensures Care Coordinators are made aware of all social services and other services and resources available locally to Enrollees and collaborates with the Program Director in sharing resource information across teams.
- Ensures that all Care Coordinators are aware of services and supports provided by all CP Affiliated Partners.
- Participates in consultation, sharing of resources and best practices with other Riverside Community Partners teams

C. Administrative

- Accepts referrals, assigns referrals to Care Coordinators and ensures Outreach, Assessment, Care Planning and reviews are done in accordance with all program requirements.
- Completes and ensures all team members complete all clinical documentation, including Assessments, Care Plans, progress notes, updates, incident reports, forms, etc. in a complete and timely manner and in compliance with organization and relevant state protocols.
- Completes and ensures all team members complete all administrative documentation, including program statistics, reporting, payroll, etc. in a complete, accurate and timely manner in compliance with organization and relevant state or payer requirements**.**
- Submits a timely and accurate compilation and submission of all requisite Community Partner monthly Member Status and other reports to the CP Director and other ad hoc reports as necessary.
- Documents and reports to the BH CP Director and Riverside QM Vice President or designee, as necessary, any grievances and/or incidents pertaining to Enrollees or CP Care Team activities and works to resolve, as appropriate in accordance with CP policies and procedures.
- Ensures team conducts surveys of a cohort of Enrollees related to complete the CP Quality Improvement initiatives.

- Assumes additional responsibility consistent with program needs and role, as defined in consultation with the BH CP Director.

General Responsibilities

- Complies with all mandated reporting requirements and regulations (i.e. DCF, DMH, DPPC, Elder Protective Services)
- Reads and follows procedures as detailed in Riverside and program policies and procedures
- Attends and utilizes supervision meetings. Brings issues of concern and/or importance to supervisor for consultation
- Maintains a professional work environment with attention to persons served and staff health and safety by maintaining protocols, alerting management to unsafe conditions, etc.
- Attends all required trainings and administrative meetings
- Other duties as may be assigned

Non –Essential Duties & Responsibilities

- There are no non-essential duties at this time.

Qualifications:

- Behavioral health related Masters Degree with Massachusetts licensure at the independent level of practice
- Experience working with people with serious mental illness and substance use disorders
- Prior supervisory experience
- Familiar with and embraces person-centered planning philosophy and motivational interviewing
- Ability to use a computer for word processing, EHR and email/Outlook Calendar, and the Internet for resource searches and assisting clients with online surveys and using online decision-making tools
- Regular access to reliable transportation required.

Physical & Mental Requirements:
Must have the physical and cognitive abilities and knowledge base to:

- Respond and work with consumers, staff, managers and external parties in a professional, respectful, and sensitive manner.
- Safely perform job functions with or without the aid of mechanical devices.
- Comprehend and carry out policies and procedures using specific instructions and accepted practices.
- Assess complex situations, collaborate and integrate different viewpoints and use good judgment when dealing with others.

- Communicate verbally and in writing in language that can be readily understood by the majority of the program's clients, staff and funders.
- Effectively perform job responsibilities in a high stress environment.
- Regular access to reliable transportation is required in order to attend required trainings, meetings and/or fulfill other responsibilities of this role.

Training Requirements:

- HIV/Infection Control
- Hepatitis B Orientation & Training
- Safety/De-escalation training
- Training sufficient to maintain licensure
- Shared decision making, if not already trained

- Community Partners Program specific initial orientation and refresher trainings annually on topics including, but not limited to the following:

k. Cultural competency;

l. Accessibility and accommodations;

m. Independent living and recovery principles;

n. MassHealth State Plan LTSS and eligibility criteria;

o. Motivational interviewing, (refresher if already trained);

p. Trauma informed care;

q. Conflict of interests, including but not limited to those described in the EOHHS BH CP Model Contract **Section 2.4.F**, and Riverside Community Partner program's mitigation strategy for conflicts of interest;

r. Health and wellness principles;

s. Person-Centered Treatment Planning processes, using curriculum approved by EOHHS; and

t. Other trainings as further directed by EOHHS or determined necessary by the Riverside Community Partner Program Leadership.

My signature below indicates that I have read and understand the content of this job description.

_____ _____

Employee Signature (Date) Immediate Supervisor Signature (Date)

Approval Date:	Senior Manager Initials:_____
Approval Date:	Human Resources Initials:_____
Revised Date:	
Revised Date:	
Program Code:	CPC Code:
Job Code:	WC Code:

RIVERSIDE COMMUNITY CARE

Job Description

Title: Nurse Care Manager

Reports to: Riverside Community Partners Clinical Care Manager/Team Leader

Program: Riverside Community Partners Team

Division: Behavioral Health Services

Job Titles Reporting to this Position: N/A

Position Summary: The Nurse Care Manager serves as a member of a Behavioral Health Community Partners (BH CP) team, providing direct care management and coordination to Enrollees, collaboration with medical and other care providers, consultation to team members regarding health needs, health behaviors and medications of the team's Enrollees, supervising any RNs on the team, and participating in the ongoing development of trainings for staff and Enrollees regarding health and health behaviors.

Essential Duties and Responsibilities:

A. Direct Service Provision

- Provide all aspects of care management and coordination services required by contract and program design to be provided by a nurse to the Enrollees of the BH CP team, including but not limited to medication reconciliation, coordination with physicians, reviewing Enrollee Assessment health information, collaborating on Assessments and Care Planning, etc.
- Consulting with BH CP staff, Medical Director and Care Team members, PCP and/or MCO/ACO regarding Enrollees' health related activities, interventions and service needs, as needed
- Communicating directly with Enrollees' via telephonic, electronic and face to face and documenting all activities as required by program policies and protocols
- In conjunction with program management and staff, help develop and/or provide training for staff and Enrollees on health and health behaviors.
- Other direct services in keeping with the Nurse Care Manager role, including serving as primary care coordinator for some Enrollees, as may be assigned by the Clinical Care Manager/Team Leader

B.. General and Administrative

- Complete all clinical documentation, including Assessments, Care Plans, progress notes, updates, incident reports, forms, etc. in a complete and timely manner and in compliance with organization and relevant state protocols.
- Completes all required administrative documentation, including but not limited to reports, statistics, timesheets, etc., in a complete, accurate and timely manner in compliance with organization and relevant state or payer requirements**.**

- **A**ssumes additional responsibility consistent with program needs and staff role, as defined in consultation with the Clinical Care Manager/Team Leader.

General Responsibilities

- Complies with all mandated reporting requirements and regulations (i.e. DCF, DMH, DPPC, Elder Protective Services).
- Reads and follows procedures as detailed in Riverside and program policies and procedures.
- Attends and utilizes supervision meetings. Brings issues of concern and/or importance to supervisor for consultation.
- Maintains a professional work environment with attention to persons served and staff health and safety by maintaining protocols, alerting management to unsafe conditions, etc..
- Attends all required trainings and administrative meetings.
- Other duties as may be assigned.

Non –Essential Duties & Responsibilities

- There are no non-essential duties at this time.

Qualifications:

- Registered Nurse with current Massachusetts license to practice. Bachelor's degree in nursing preferred.
- Experience with people with mental illness and substance use disorders, with at least one year of providing care to individuals with medical problems preferred.
- Embraces person-centered planning philosophy
- Ability to use a computer for word processing, EHR and email/Outlook Calendar
- Regular access to reliable transportation is required in order to attend required trainings, meetings and/or fulfill other responsibilities of this role.

Physical & Mental Requirements:
Must have the physical and cognitive abilities and knowledge base to:

- Respond and work with consumers, staff, managers and external parties in a professional, respectful, and sensitive manner.
- Safely perform job functions with or without the aid of mechanical devices.
- Comprehend and carry out policies and procedures using specific instructions and accepted practices.
- Assess complex situations, collaborate and integrate different viewpoints and use good judgment when dealing with others.
- Clearly communicate verbally and in writing in language that can be readily understood by the majority of the program's clients, staff and funders.
- Effectively perform job responsibilities in a high paced environment.

Training Requirements:

- HIV/Infection Control
- Hepatitis B Orientation & Training
- Safety/De-escalation training
- Training sufficient to maintain licensure
- Shared decision making, if not already trained
- Community Partners Program specific initial orientation and refresher trainings annually on topics including, but not limited to the following:

a. Cultural competency;

b. Accessibility and accommodations;

c. Independent living and recovery principles;

d. MassHealth State Plan LTSS and eligibility criteria;

e. Motivational interviewing, (refresher if already trained);

f. Trauma informed care;

g. Conflict of interests, including but not limited to those described in the EOHHS BH CP Model Contract **Section 2.4.F**, and Riverside Community Partner program's mitigation strategy for conflicts of interest;

h. Health and wellness principles;

i. Person-Centered Treatment Planning processes, using curriculum approved by EOHHS; and

j. Other trainings as further directed by EOHHS or determined necessary by the Riverside Community Partner Program Leadership.

My signature below indicates that I have read and understand the content of this job description.

_____ _____

Employee Signature (Date) Immediate Supervisor Signature (Date)

Approval Date:	Senior Manager Initials:_____
Approval Date:	Human Resources Initials:_____
Revised Date:	
Revised Date:	
Program Code:	CPC Code:
Job Code:	WC Code:

RIVERSIDE COMMUNITY CARE

Job Description

Title: Care Coordinator

Reports to: Clinical Care Manager/Team Leader

Program: Riverside Community Partners Team

Division: Behavioral Health Services

Job Titles Reporting to this Position: N/A

Position Summary: The Care Coordinator serves as a member of a Behavioral Health Community Partners (BH CP) team, providing person-centered and recovery oriented care management and coordination to assigned Enrollees, including but not limited to outreach and engagement, assisting Enrollees to identify goals and to develop an individual care plan, completing comprehensive Assessments, facilitating Care Teams, and coordinating communication among Enrollees, their healthcare and other providers, involved state agencies and others, and supporting Enrollees to access and utilize resources to improve and maintain their health and quality of life.

Essential Duties and Responsibilities:

A. Direct Service Provision

- Conducts outreach and engagement activities to encourage CP enrollment, including ensuring mechanisms for communication among Enrollees and others involved in Enrollees' care in all aspects of assessment and care planning and coordination activities.
- Functions as primary care coordinator for assigned Enrollees, face to face, telephonic and electronic outreach and ongoing communication
- Completes comprehensive Assessments, Person-Centered Care Plans and updates as required by program protocols and policies in conjunction with Enrollees, their Care Teams and other BH CP team members
- Facilitates communication and collaboration among all Enrollees' health and behavioral health care providers, family and community resources, especially during times of transitions between levels of care or when changes to the Person-Centered Care Plan are made, supporting Enrollees to actively engage in medical, behavioral health, social services, wellness activities and other resources to promote their health and well being
- Coordinates with the Nurse Care Manager, Clinical Care Manager, and others to ensure all aspects of the BH CP services are approved, provided and reviewed as needed and in accordance with program protocols and policies
- Organizes and facilitates Care Team meetings
- Maintains regular contact with Enrollees (and their families when appropriate)

- Assists Enrollees with navigating through all systems of care, provides referrals to appropriate services and supports, coaches and assists Enrollee to attain health and wellness goals

- Other duties as appropriate to the Care Coordinator role and as may be assigned

B. General and Administrative

- Complete all clinical documentation, including Assessments, Care Plans, progress notes, updates, incident reports, forms, etc. in a complete and timely manner and in compliance with organization and relevant state protocols.

- Completes all required administrative documentation, including but not limited to reports, statistics, timesheets, etc. in a complete, accurate and timely manner in compliance with organization and relevant state or payer requirements**.**

- Assumes additional responsibility consistent with program needs and staff role, as defined in consultation with the Clinical Care Manager/Team Leader.

General Responsibilities

- Complies with all mandated reporting requirements and regulations (i.e. DCF, DMH, DPPC, Elder Protective Services)

- Reads and follows procedures as detailed in Riverside and program policies and procedures

- Attends and utilizes supervision meetings. Brings issues of concern and/or importance to supervisor for consultation

- Maintains a professional work environment with attention to persons served and staff health and safety by maintaining protocols, alerting management to unsafe conditions, etc.

- Attends all required trainings and administrative meetings

- Other duties as may be assigned

Non –Essential Duties & Responsibilities

- There are no non-essential duties at this time.

Qualifications:

- Bachelor's degree in a behavioral health or social service field and/or two years of experience working with people with mental health and/or substance use disorders; or

- Embraces person-centered planning philosophy

- Lived experience as a consumer of behavioral health services with Peer Specialist training desirable

- Ability to use a computer for word processing, EHR and email/Outlook Calendar, and the Internet for resource searches and assisting clients with online surveys and using online decision-making tools

- Regular access to reliable transportation is required in order to attend required trainings, meetings and/or fulfill other responsibilities of this role.

Physical & Mental Requirements:
Must have the physical and cognitive abilities and knowledge base to:

- Respond and work with consumers, staff, managers and external parties in a professional, respectful, and sensitive manner.
- Safely perform job functions with or without the aid of mechanical devices.
- Comprehend and carry out policies and procedures using specific instructions and accepted practices.
- Assess complex situations, collaborate and integrate different viewpoints and use good judgment when dealing with others.
- Clearly communicate verbally and in writing in language that can be readily understood by the majority of the program's clients, staff and funders.
- Effectively perform job responsibilities in a high paced environment.

Training Requirements:

- HIV/Infection Control
- Hepatitis B Orientation & Training
- Safety/De-escalation training
- Training sufficient to maintain licensure
- Shared decision making, if not already trained
- Community Partners Program specific initial orientation and refresher trainings annually on topics including, but not limited to the following:

    u. Cultural competency;

    v. Accessibility and accommodations;

    w. Independent living and recovery principles;

    x. MassHealth State Plan LTSS and eligibility criteria;

    y. Motivational interviewing, (refresher if already trained);

    z. Trauma informed care;

    aa. Conflict of interests, including but not limited to those described in the EOHHS BH CP Model Contract **Section 2.4.F**, and the Riverside Community Partner program's mitigation strategy for conflicts of interest;

    bb. Health and wellness principles;

cc. Person-Centered Treatment Planning processes, using curriculum approved by EOHHS; and

dd. Other trainings as further directed by EOHHS or determined necessary by the Riverside Community Partner Program Leadership.

My signature below indicates that I have read and understand the content of this job description.

_____

Employee Signature (Date) Immediate Supervisor Signature (Date)

Approval Date:	Senior Manager Initials:____
Approval Date:	Human Resources Initials:_____
Revised Date:	
Revised Date:	
Program Code:	CPC Code:
Job Code:	WC Code:

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Section 7.3 F. Implementation and Timelines

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Section 7.3 Initial DSRIP Participation Plan
F. Implementation and Timelines

The Bidder shall attach timelines that display the Bidder's monthly implementation plans for the Preparation Budget Period, and quarterly implementation plans for each subsequent Budget Period. The timelines shall include all necessary operational activities to meet the Contractor Requirements described in Attachment A.

Attachments 1 and 2 below contain the requisite timelines.

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Section 7.3 F. Implementation and Timelines

Attachment 1: Monthly Implementation Plan for the Preparation Period

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Section 7.3.F. Attachment 1

Riverside's Monthly Implementation Plan for the Preparation Budget Period

RIVERSIDE COMMUNITY PARTNER IMPLEMENTATION PLAN AND TIMELINE

	Prep Period						
Activities	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
Formalize Relationships with ACOs/MCOs							
Establish MOUs with ACOs/MCOs in each covered service area		x	x	x	x	x	x
Establishment of CP Oversight and Electronic Processes							
Establish CP Governance Committee		x					
Katherine and Nora visit AP provider sites to become familiar with the areas.			x				
IT support consultant hired and supports Riverside IT start-up activities				x	x	x	x
Configure software and set up databases				x	x	x	x
Establish policies and procedures for information sharing, Electronic Health Record utilization, and Mass HIway connections with ACOs, MCOs, Affiliated Partners, and others.			x	x	x	x	x
Establish processes for monitoring and ensuring completeness/accuracy of all data and documentation collected, stored and reported by APs and submitted to EOHHS			x	x	x	x	x
Establish processes for electronic receipt of assignments, noticing EOHHS, and Enrollee information recordkeeping and transimission pursuant to the CP contract requirements				x	x	x	x
Develop standardized electronic report formats and mechanisms for collecting, tracking, and storing information from outreach activities, assessment, person-centered planning, and other CP tools				x	x	x	x
Develop databases/processes for collecting and storing information re: grievances & resolutions, critical incidents and clinical quality and measurement				x	x	x	x
Enable electronic System to collect, store and generate reports in requisite formats to EOHHS re: Qualifying Activities, Member Status, Quality Measures, Critical Incidents and other information pursuant to CP contract and per EOHHS				x	x	x	x
Establish Community Partner Team Offices & Purchase Equipment							
ID and obtain office space for teams and begin major purchases of supplies/equipment.			x	x	x	x	x
Purchase first batch (17) of laptop computers and associated software not already owned					x		
Community Partner Staffing							
Katherine Powell AVP for BH services begin overseeing CP director's start up efforts	x						
Nora Kenny-Houser starts as CP Director	x						
CP Team staff recruitment/hiring						x	x
Develop CP Team training curriculum						x	x
CP Team staff training, additional staff trained as brought on						x	x
Receive first list of assignees for June 1 outreach- Nora provides each AP with their list							x
Quality Management and Quality Committee							
Convene Quality Committee and develop Quality Improvement plan for EOHHS submission				x	x	x	
Finalize Y1 QI initiative and implementation data collection tools/processes						x	x
Develop & Finalize Rules, Practices, Policies, Procedures, Resource Directory, and Report Formats							
Submit tools/policies for EOHHS review and approval, as required and finalize	**When/As Required**						
Develop with APs templates for person-centered planning, medication reconciliation documentation and social services assessment - complete by readiness review				x	x		
Develop community resources directory, update as necessary						x	

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Section 7.3.F Implementation Plan and Timelines

Attachment 2: Quarterly Implementation Plans for the Budget Periods 1-5

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Section 7.3.F. Attachment 2
Riverside's Quarterly Implementation Plan for Budget Periods 1-5

RIVERSIDE COMMUNITY PARTNER IMPLEMENTATION PLAN AND TIMELINE

Activities	Budget Period 1				Budget Period 2				Budget Period 3				Budget Period 4				Budget Period 5			
	Qtr1	Qtr2	Qtr3	Qtr 4	Qtr1	Qtr2	Qtr3	Qtr 4	Qtr1	Qtr2	Qtr3	Qtr 4	Qtr1	Qtr2	Qtr3	Qtr 4	Qtr1	Qtr2	Qtr3	Qtr 4
Community Partner Team Offices & Equipment Purchases																				
Purchase next 50 laptop computers budgeted	x																			
Community Partner Staffing																				
CP Teams take assignments and work with Assigned/Engaged Enrollees	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Hire/Train new staff as necessary as caseloads grow/turnover may warrant	When/As Needed																			
Continue to develop/modify/expand CP Team training curriculum	x	x																		
Submit Requisite Monthly and Quarterly Reports to EOHHS																				
Submit Monthly Member Status/Qualfiying Activity reports to EOHHS	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Develop and submit other reports to EOHHS on request	When/As Requested																			
Quality Management and Quality Committee																				
Implement Y1 QI initiative and each year, implement new or modified QI initiative.	x				x				x				x				x			
Submit Clinical Quality Measure/other quality management reports to EOHHS as requested	When/As Requested																			
Submit annual QI Initiative reports				x				x				x				x				x
Convene Critical Incident/Grievance Review Committee, as necessary	When/As Needed																			
CP Operations - Oversight, Electronic Processes and Management																				
Complete implementation of processes for monitoring and ensuring completeness/accuracy of all data and documentation collected, stored and reported by APs and submitted to EOHHS	x																			
Complete implementation of electronic system to collect, store and generate reports in requisite formats re: Qualifying Activities, Member Status, Quality Measures, Critical Incidents and other information	x																			
Collaborate with Affiliated Partners and Consumer Advisory Board on reviewing operations information and Enrollee feedback and identifying operational issues. Design and implement operational	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Consumer Advisory Board																				
Identify and invite Engaged Enrollees to be participants	x																			
Convene first meeting and establish quarterly meeting schedule, conduct quarterly meetings	x				x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

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Section 7.3.G Budget Report and Budget Narrative
(See Revised Budgets/Narratives)

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Section 7.3 Initial DSRIP Participation Plan

G. Budget Report and Budget Narrative and Attachments (See Revised Budget Reports and Narratives and attachments provided separately on / 12-05-17, as instructed, in a separate EXCEL file.)

Section 7.3 Initial DSRIP Participation Plan

G. Budget Report and Budget Narrative (This Section to be Replaced with Excel File provided 12/5/17)

The Bidder shall submit a Budget Report and Budget narrative, using Attachments B and C. The Budget Report shall be based on the number of Assigned and Engaged Enrollees in each Service Area by the Bidder on Attachment D. For purposes of preparing the Bidder's Infrastructure Budget response to this Section 7.3.G, Bidders should assume the following levels of funding:

1. **A total funding of $450,000 for the Preparation Budget;**
2. **$35 per Enrollee per month within Budget Period 1 (duration of 9 months);**
3. **$25 per Enrollee per month within Budget Period 2 (duration of 12 months);**
4. **$15 per Enrollee per month within Budget Period 3 (duration of 12 months)**
5. **$10 per Enrollee per month within Budget Period 4 (duration of 12 months;**
6. **$5 per Enrollee per month within Budget Period 5 (duration of 12 months).**

For purposes of preparing the Bidder's Program Budget response, the Bidder should refer to Appendix F of Attachment A. Attachment B must be completed and submitted in an Excel format to EOHHS

Attachments 1 and 2, below contain the budget report and budget narrative. (In the electronic submission, Attachment 1, the Budget Report, is also provided in its original EXCEL format).

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Attachment 1 to Section 7.3.G. Budget Report
(All to be Replaced with Excel File provided 12/5/17)
(created using Attachment B of the RFR)

Attachment.1 to Section 7.3.G contains the Attachment B Budget Report which includes:

- **Community Partner Program Budget Report;**
- **Community Partner Infrastructure Budget Report; and**
- **Community Partner Infrastructure Allocation Worksheet**

(Note: In our electronic submission of this response Attachment 7.3.G.1 is also provided in an EXCEL file created using RFR Attachment B)

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Attachment 1 to Section 7.3.G.
Riverside Community Care Inc. Community Partner Program Budget Report

Community Partner Program Budget Report							
	Riverside Community Care, Inc.						
Program Revenue	**Estimated Members Supported (Monthly Average)**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
Budget Year 1	3,040	$ 4,924,800					$ 4,924,800
Budget Year 2	3,230		$ 6,976,800				$ 6,976,800
Budget Year 3	3,420			$ 7,387,200			$ 7,387,200
Budget Year 4	3,610				$ 7,797,600		$ 7,797,600
Budget Year 5	3,800					$ 8,208,000	$ 8,208,000
TOTAL REVENUES							$ 35,294,400
Program Expenses		**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Salary and Benefits		$ 4,269,964	$ 5,778,684	$ 5,865,364	$ 5,953,345	$ 6,042,645	$ 27,910,002
Contract Services (consulting, professional)		$ -	$ -	$ -	$ -	$ -	$ -
Occupancy (rent, utilities, maintenance)		$ 556,875	$ 753,638	$ 764,942	$ 776,416	$ 788,062	$ 3,639,933
Training & Professional Development		$ 28,500	$ 38,570	$ 39,149	$ 39,736	$ 40,331	$ 186,286
Insurance		$ 43,125	$ 58,363	$ 59,238	$ 60,127	$ 61,027	$ 281,880
Travel		$ 125,625	$ 170,013	$ 172,563	$ 175,151	$ 177,778	$ 821,130
Equipment		$ 129,750	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 329,750
Supplies		$ -	$ -	$ -	$ -	$ -	$ -
Printing, Copying & Postage		$ 21,563	$ 29,181	$ 29,619	$ 30,063	$ 30,514	$ 140,940
Marketing		$ -	$ -	$ -	$ -	$ -	$ -
Conferences, meetings, etc.		$ -	$ -	$ -	$ -	$ -	$ -
Administration		$ 589,996	$ 784,143	$ 795,820	$ 807,671	$ 819,701	$ 3,797,331
***Other -Bad Debt**		$ 172,368	$ 244,188	$ 258,552	$ 272,916	$ 287,280	$ 1,235,304
***Other -_____**		$ -	$ -	$ -	$ -	$ -	$ -
TOTAL EXPENSES							$ 38,342,556
						Surplus/Loss	$ (3,048,156)

* Over $1,000 Please Specifiy

Attachment 1 to Section 7.3.G.
Riverside Community Care Inc. Community Partner Infrastructure Budget Report

Community Partner Infrastructure Budget Report

	Riverside Community Care, Inc.							
Infrastructure Funds	**Estimated Members Supported (Monthly Average)**	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
Prep Period		$ 450,000						
Budget Year 1	3,040		$ 957,600					$ 957,600
Budget Year 2	3,230			$ 969,000				$ 969,000
Budget Year 3	3,420				$ 615,600			$ 615,600
Budget Year 4	3,610					$ 433,200		$ 433,200
Budget Year 5	3,800						$ 228,000	$ 228,000
TOTAL FUNDS								$ 3,203,400
Infrastructure Investments		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology								
		$ 75,000	$ 173,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 373,000
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs								
		$ 343,000	$ 784,600	$ 919,000	$ 565,600	$ 383,200	$ 178,000	$ 2,830,400
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
		$ 32,000	$ -	$ -	$ -	$ -	$ -	$ -
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL INVESTMENTS								$ 3,203,400
							Surplus/Loss	$ -

Attachment 1 to Section 7.3.G.
Riverside Community Care Inc. Community Partner Infrastructure Allocation Worksheet

Community Partner Infrastructure Allocation Worksheet

	Riverside Community Care, Inc.							
Infrastructure Funds	**Estimated Members Supported (Monthly Average)**	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
Prep Period		$ 450,000						
Budget Year 1	3,040		$ 957,600					$ 957,600
Budget Year 2	3,230			$ 969,000				$ 969,000
Budget Year 3	3,420				$ 615,600			$ 615,600
Budget Year 4	3,610					$ 433,200		$ 433,200
Budget Year 5	3,800						$ 228,000	$ 228,000
TOTAL FUNDS								$ 3,203,400
Infrastructure Investments		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology								
Riverside Community Care		$ 17,857	$ 41,190	$ 11,905	$ 11,905	$ 11,905	$ 11,905	$ 88,810
North Suffolk MH Assoc.		$ 17,857	$ 41,190	$ 11,905	$ 11,905	$ 11,905	$ 11,905	$ 88,810
Lynn Community HC		$ 17,857	$ 41,190	$ 11,905	$ 11,905	$ 11,905	$ 11,905	$ 88,810
The Edinburg Center		$ 10,716	$ 24,716	$ 7,142	$ 7,142	$ 7,142	$ 7,142	$ 53,284
Brookline CMHC		$ 3,571	$ 8,238	$ 2,381	$ 2,381	$ 2,381	$ 2,381	$ 17,762
The Dimock Center		$ 3,571	$ 8,238	$ 2,381	$ 2,381	$ 2,381	$ 2,381	$ 17,762
Upham's Corner HC		$ 3,571	$ 8,238	$ 2,381	$ 2,381	$ 2,381	$ 2,381	$ 17,762
Workforce Development								
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs								
Riverside Community Care		$ 81,667	$ 186,810	$ 218,810	$ 134,667	$ 91,238	$ 42,381	$ 673,906
North Suffolk MH Assoc.		$ 81,667	$ 186,810	$ 218,810	$ 134,667	$ 91,238	$ 42,381	$ 673,906
LynnCommunity HC		$ 81,667	$ 186,810	$ 218,810	$ 134,667	$ 91,238	$ 42,381	$ 673,906
The Edinburg Center		$ 49,000	$ 112,084	$ 131,284	$ 80,800	$ 54,742	$ 25,429	$ 404,339
Brookline CMHC		$ 16,333	$ 37,362	$ 43,762	$ 26,933	$ 18,248	$ 8,476	$ 134,781
The Dimock Center		$ 16,333	$ 37,362	$ 43,762	$ 26,933	$ 18,248	$ 8,476	$ 134,781
Upham's Corner HC		$ 16,333	$ 37,362	$ 43,762	$ 26,933	$ 18,248	$ 8,476	$ 134,781
Operational Infrastructure								
Riverside Community Care		$ 32,000	$ -	$ -	$ -	$ -	$ -	$ -
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
		$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL INVESTMENTS								$ 3,203,400
							Surplus/Loss	$ -

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Attachment 2 to Section 7.3.G. Budget Narrative
(To be Replaced with Excel File provided 12/5/17)

The following Budget Narrative, created using the RFR Attachment C Budget Narrative, includes:

- **Community Partner Budget Narrative Part I: Program Expenses; and**
- **Community Partner Budget Narrative Part II: Infrastructure Expenses**

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Attachment 2 to Section 7.3.G 2. Community Partner Budget Narrative (Developed using BH CP RFR Attachment C) (To be Replaced with Excel File provided 12/5/17)

Part I: Program Expenses:
(Expense narrative should only include expenses listed in the Program Budget. Please include a narrative for expenses listed in the Infrastructure Budget in Part II.)

Salary **Total:** $22,060,065

In the box below, please provide a description that includes: (1) the title of the position, (2) a brief statement of the position's primary responsibility, (3) an approximate amount of time the staff member will spend performing tasks related to the Contract, (4) the position's salary, and (5) the length of time the position will be staffed during the relevant Budget Period.
(e.g. Program Director currently oversees the program and will spend 100% of their time hiring, supervising and training staff. This individual's annual salary is $67,575.00 and will be covered for the 12 months of the Budget Period.)

Riverside and our Affiliated Partners have committed to serve up to 3,800 people, but we are flexible should referral patterns and volume be lower or higher. To serve this number of MassHealth Enrollees will require a total of 9.5 teams. We believe that our local model, flexibility, and experience will serve Enrollees well. Please note that our budget assumes we will reach 80% of capacity in Budget Year one, recognizing it will take time to build to full caseloads. Since we can add staff as the caseloads grow, we anticipate being able to match staffing with volume. In estimating revenue from projected capacity, we used $180 PMPM for our calculations. We understand that CBFS Enrollees will be reimbursed at a higher rate, but also that not all budgeted capacity may be filled each month. Therefore, using $180 for all budgeted Enrollees represents our best overall means of estimating potential revenue.

There are two categories of salary associated with Riverside Community Partners. First there are the central BH CP program administrative positions necessary to manage the overall program. The Senior Manager assigned to this project, Jason Moscato, RN MS, LMHC is allocated to Riverside Community Partners as a .375 FTE for $39,750 annually; he is a member of Riverside's Leadership Team and Supervises the Program Director. The Program Director is Nora Kenny-Houser and is dedicated to the program full time. She is responsible for the day to day operation of Riverside Community Partners, including oversight of our Affiliated Partners. This position is budget at $80,000. Two full-time administrative support positions are also included in the budget. Each is budget at $42,000 and will work solely for this program. One position, the Contract Administrator will focus on contract management and monitoring, preparing claims, reports, and related information and submissions. The other Administrative Assistant will serve as the coordinator of meetings, projects, and provide general support. Dedicated centralized quality management staffing is also included for .2FTE at $19,000 annually. This position will be a member of Riverside's Quality Management Department.
The second category of salaries includes the core staffing for each of our planned 9.5 care management teams. Core staffing will include a full-time Clinical Care Manager/Team Leader who manages each locally-based team. This position is budgeted at $65,000. A full-time nurse for each team will ensure the medical needs of the people we serve are met on a day to day basis. This position is also budgeted at $65,000. The eight Care Coordinators for each team will provide most of the direct services for the program and will each be paid $40,000. One hour of psychiatry, the Team (Medical Director) is budgeted at $6,000 annually. Each Affiliated Partner may adjust the model of their team(s), including salaries, to align with their own organization's compensation plan, as long as they meet all contractual obligations. We will provide back-up documentation for all salary expenditures should MassHealth require it.
Please note that all salaries, benefits and most other costs are budgeted to increase 1.5% annually in the five year

budget model provided in Attachment B Community Partner Program Budget Report.

Fringe **Total:** $5,849,937

In the box below, please provide a description of all line items within the fringe category. Example line items include FICA, Medicare, Unemployment, Health Insurance, Retirement, etc. Please include the fringe benefit rate, breaking it down by line item and percentage rates.
(e.g. FICA will be paid for all salaries: $54,818.00 x .0765 = $4,194.00.
Unemployment cost is $17,300.00 x 3 x .03 = $2,855.00.
Health Insurance cost for full-time employees is…)

We have established a base fringe and payroll tax rate for the purpose of this proposal of 20.96%. This is Riverside's anticipated fringe rate for FY'18 and is budgeted to increase 1.5% annually over the five year period. The rate consists of payroll taxes of 8.54%, health, dental, disability, and life insurance of 12.42%. The detail is as follows: FICA is 7.17%; Unemployment is .38%; Worker's Compensation is .84%; MassHealth Tax is .15%. Detail on other benefits is: medical at 11.84%; dental at .29%; disability at .08%; tuition reimbursement at .07%; and life insurance at .14%. As with all budget items, our Affiliated Partners may have variations in expenditures. We will provide back-up documentation for expenditures should MassHealth require it.

Training and Professional Development **Total:** $186,286

In the box below, please provide a description of all line items within the Training and Professional Development category.
(e.g. Two Care Coordinators will be pursuing their LICSWs. Cost of exam $260 x 2 = 520.)

Approximately $3,000 has been budgeted per team for Training and Professional Development for the first nine months of operation (Budget Period 1). This assumes that $300 is available for each employee or that the money may be pooled for specific trainings to be held for all staff at the program. Training and Professional Development expenses are budgeted to increase 1.5% annually. We will provide back-up documentation for expenditures should MassHealth require it.

Travel **Total:** $821,130

In the box below, please provide a description of all line items within the Travel category. Examples of local travel justifications include the number/types of MBTA passes, MBTA tokens, number of trips/cost per trip and trip destinations. The IRS approved business mileage rate for Calendar Year 2017 is 53.5 cents per mile. For other travel, particularly if outside the Service Area, you must clearly describe the need and cost detail.
(e.g. Program Director 300 miles x .0445 = $134; Care Coordinator 200 miles x 0.445 = $89)

This line item includes mileage to visit Enrollees or to look for them, as well as travel for trainings and meetings. We have budgeted approximately $4,500 for the central administrative staff and approximately $12,750 per team for the first nine months of operation (Budget Period 1), at Riverside's current reimbursement rate of $0.45 per mile, it allows for approximately 2,833 miles per BH CP team member for that nine month period. Travel is budgeted to increase by 1.5% annually.

Equipment **Total:** $329,750

In the box below, please provide a description of all line items within the Equipment category. Please provide a description that lists the equipment, the intended purpose of each equipment item and how the estimated costs were determined. These costs should only include the costs to purchase new equipment to support the performance under the Contract.
(One computer package including printer, scanner will be purchased. Cost= $853.00. This cost is based on a quote from our organization's account with Dell. The computer will be based in the administrative office and will be used to conduct administrative work connected to this program.)

We plan to purchase 50 computers utilizing Prep Budget Period DSRIP dollars prior to acceptance of referrals. We will purchase approximately another 50 laptop computers during Budget Period 1. At $1,500 per Dell computer, this is $75,000 in that period. In addition, we will need to purchase other equipment such as desks, phones, printers, and copiers. In Budget Period 1 we have budgeted approximately $548 per employee over the nine month period. In subsequent budget periods we have estimated an annual equipment expense of $50,000 each year to cover the cost of new and replacement equipment across all the 9.5 teams and central program administration.

Supplies **Total:** $140,940

In the box below, please provide a description of all items that will be purchased within the Supplies category. Supplies are those items considered tangible, expendable. Examples include general office supplies, postage costs, meeting costs/supplies, copies, printing costs and materials. Purchased materials and supplies shall be charged at their actual prices, net of applicable credits. Care should be taken to identify those supplies directly tied to the Community Partner Program.
(e.g. Binders to use for paperwork to conduct home visits- 12.95 each x 15= $194.25)

We have budgeted $21,563 for supplies including office supplies, printing, and postage for the nine month Budget 1 period. This appears on the Printing, Copying & Postage line on Attachment B Community Partner Program Report. We are budgeting approximately $100 per employee across all teams and central program administration for costs such as business cards, paper, pens, notebooks, and other related items. The remaining funds in this category are expected to be spent on printing (marketing) materials and mailing costs. We budgeted a 1.5% increase in this line item for Budget Years 2-5. We will provide back-up documentation for expenditures should MassHealth require it.

Occupancy **Total:** $3,639,933

In the box below, please provide a description of all line items within the Occupancy category. For each line item, please provide a description of how the costs were estimated such as square footage and the proportionate amount of space occupied by the Community Partner Program.
(e.g. Monthly rent and utilities cost is necessary for the site location to provide the services and activities. The cost is pro-rated at 50% for Rent and Utilities because the other half of the facility is utilized for a Department of Mental Health Contract that covers the other 50% of the cost. Rent: $600.00 a month (pro-rated 50% of usage) $300.00 x 12 months= $3,600.00. Utilities: $300.00 a month (pro-rated 50% of usage) $150.00 x 12 months= $1,800.00. Repair/Maintenance: $50 a month x 12 months= $600.00.)

For the initial nine months in Budget Year 1, each team is allocated $56,250 and central administration is allocated $22,500. Budgeted occupancy costs for full 12 month periods is $75,000 per BH CP team, per year and $30,000 for Riverside Community Partners central administration. We have included a 1.5% increase in this expense in subsequent years. This is inclusive of rent, utilities, repairs/maintenance, depreciation for construction, etc.) We anticipate completing basic renovations for an annual expense of $26,500 which would be built into the rent. It assumes offices of approximately 1,800 square feet per team at a base cost of $21 per square foot. We will provide back-up documentation for expenditures should MassHealth require it.

Contract Services **Total:** N/A

In the box below, please provide a description of all line items within the Contract Services category. This category is for all contractual services relevant to the Contract. Your justification should include the total costs, the name of the individuals/organizations, the services or goods being provided and the rate.

N/A

Other **Total:** $1,235,304

In the box below, please provide a description of all line items within the Other Services category.

We have made the assumption that there will be a 3.5% bad debt rate. We have increased this estimate by 1.5% of the base estimate each year. We understand that we may not be able to be reimbursed for all Enrollees every month due to requirements such as Qualifying Activities and Engagement deadlines and/or changes in Enrollees' MassHealth status. We will provide backup documentation for expenditures should MassHealth require it.

Part II: Infrastructure Expenses:

(Investment narrative should only include investments listed in the Infrastructure Budget. Please provide separate descriptions of budget allocations for each Consortium Entity, Affiliated Partners and Material Subcontractors)

Technology **Total:** $448,000

In the box below, please provide a description of all line items within the Technology Investment category. Please explain how these investments will support the Contractor's performance of the Contract.
(e.g. Health Information Technology and care management software, IT project management resources, data analytics capabilities, mobile technology including tablets, laptops and smartphones for CP staff and reporting software)

Prep Budget-Technology Investments:

A total of $75,000 will be distributed across Riverside Community Partners in this category. Each Affiliated Partner is able to choose the equipment in this category that best meets their needs in meeting the requirements described in the RFR. This equipment will be primarily laptops with the capacity for electronic signatures by Enrollees. Riverside's current pricing for Dell laptops that have a touch screen, microphones, cameras, speakers, and eSig software is $1,500 each.

Year 1 Budget-Technology Investments:

We have budgeted a total of $173,000 for additional technology investment for year one, assuming that equipment purchase will continue in this period.

Years 2-5 Budget-Technology Investments:

We have budgeted $50,000 for each year in this period to allow for continued purchase of equipment, including enhancements and replacements as needed.

Workforce Development **Total:** N/A

In the box below, please provide a description of all items within the Workforce Development Investment category. Please be sure to document how these investments will assist in meeting the terms of the contract.
(e.g. recruitment support, training and coaching programs and certifications)

Prep Budget Workforce Development Investments:

N/A

Year 1 Budget Workforce Development Investments:

N/A

Years 2-5 Budget Workforce Development Investments:

N/A

Business Start-Up **Total:** $3,173,400

In the box below, please provide a description of all items within the Business Start-Up Investment category. Please be sure to document how these investments will assist in meeting the terms of the contract.

(e.g. staffing and startup costs to develop full caseloads)

Prep Budget Business Start-Up Investments:

During the Prep Budget period we have budgeted $343,000 in this category to be used to hire and train staff ahead of the go-live date. During start-up there are two categories of salary associated with Riverside Community Partners. First, there is management necessary for start-up and ongoing oversight of the program. This salary line is a total of $60,249. With fringe and payroll taxes of $12,628 (20.96%) the total is $72,877. This category includes the member of Riverside's Senior Management assigned to this program, Jason Moscato, RN, MS, LMHC who is dedicated .375FTE, costing $39,750 annually. This position is budgeted for four months at $13,250. The full-time Program Director is Nora Kenney-Houser, LICSW at $80,000 annual salary. She is budgeted for four months at a cost of $26,666. Two full-time Administrative Support staff will be hired at $42,000 each annually and are included for two months at $7,000 each for a total of $14,000. A Quality Manager will be assigned to this program at .2FTE at a salary of $95,000. In this period the QM is budgeted for four months at a cost of $6,333.

Each position plays a central role in the project and will be critical participants in the preparation prior to go-live. The Program Director is responsible for ensuring Riverside and our Affiliated Partners meet all requirements, evaluating and coordinating best practices, and helping to design the processes for data flow. The Senior Manager is responsible for oversight and assisting the Program Director in collaborating with Affiliated Partners and ACOs/MCOs and MassHealth. The Quality Manager will provide direction in carrying out QI initiatives, monitoring documentation and contract compliance. The two Administrative Support positions will focus on coordinating information flow necessary to meet reporting and billing requirements, collecting data, support analysis, and ensuring billing is timely and correct. As note, we are phasing in the personnel for these positions to ensure we are prepared for operations.

The second category of salary associated with this project includes core staffing for the BH CP teams at Riverside and each Affiliated Partner. In the Prep Budget Period we have budgeted $270,123 for this, inclusive of salary and fringe and payroll tax. Core staffing includes a full time Clinical Care Manager who leads each team as well as a full time nurse, eight Care Coordinators, and a part-time psychiatrist (Medical Director). Each Affiliated Partner may design and operate a modified model for their team as long as they meet all contractual obligations.

Riverside and each Affiliated Partner will receive funds for staffing start-up (pre-caseload) so that staff can be hired, trained and participate as appropriate in final program development. We are apportioning funds for this purpose to enable each team to use funding in a manner that works best for them. Our basic salary structure is that the Clinical Care Manager/Team Leaders will be paid $65,000 annually, that nurses will be paid $65,000 annually, and that the Care Coordinators will be paid $40,000 annually. Our Affiliated Partners may adjust these salaries consistent with their particular compensation models. Riverside and each Affiliated Partner will utilize the funds provided to begin to build our teams. There will be variations in salary, as well as weeks and hours worked by each person.

A total of $270,123 has been allocated across teams based on a formula which assumes the size of each Affiliated Partner's planned service volume (and therefore number of staff needed). That formula is as follow: For Affiliated Partners planning the largest volume (Riverside, Lynn and North Suffolk) each will receive $64,315 toward staffing; Affiliated Partners planning medium volume (Edinburg) will receive $38,589; Affiliated Partners planning smaller volume (Upham's Corner, Brookline CMHC, Dimock) each will receive $12,863. The amounts allocated to each organization will be utilized for team members' salaries, tax and fringe, allowing each organization to use their allocation flexibly as described above. We will provide back-up documentation for expenditures should MassHealth require it.

Year 1 Budget Business Start-Up Investments:

We have budgeted $784,600 for the nine months of Budget Year 1 to be used to continue bringing staff onto the BH CP teams ahead of full caseloads, and while staff time will also be in initial orientation and training about the BH CP

program. As above, the funds will be used for salaries for team members and for tax and fringe, with flexibility so that each Affiliated Partner is able to apply the funds in the best way possible according to their initial staffing needs, their particular compensation model, and their actual tax and fringe expenses applicable during that period of time. The funds will be allocated according to volume of Enrollees managed by each team, in keeping with the plan for DSRIP to be determined by a PMPM. Our estimated allocation among Affiliated Partners is delineated in the Attachment B Infrastructure Allocation Worksheet.

Year 2-5 Budget Business Start-Up Investments:

We have budgeted a total of $2,045,800 for years two-five to continue to be used to bring on additional staff while we continue to ramp up, as staff do not yet have full caseloads, as new hires need to be oriented and trained on the BH CP program, and as all staff will need to participate in continued trainings as we continue development of training curricula with the benefit of our developing experience and knowledge of the BH CP program. We assume that full volume and full caseloads will be achieved during year five. We also assume that there will be staff turnover during these budget periods, due both to the usual rhythm of employees moving on from jobs and because as a new and innovative model, some staff will discover that the work is or is not what they envisioned or want to commit to. As above, the funds will be used flexibly by the teams to cover salaries, taxes and fringe. We intend to distribute the funds among Affiliated Partners according to actual volume, in keeping with the plan for DSRIP to be determined by a PMPM. Our estimated allocation across Affiliated Partners is delineated in Attachment B Infrastructure Allocation Worksheet.

Operational Infrastructure **Total:** $32,000

In the box below, please provide a description of all items within the Operational Infrastructure Investment category. Please be sure to document how these investments will assist in meeting the terms of the contract. *(e.g. project management, system change resources and performance management capabilities, additional operational support)*

Prep Budget-Operational Infrastructure Investments:

We intend to contract for information technology services to support initial start-up so that each participating organization has a resource to ensure they are able to operate on the go-live date. This contracted resource will be overseen by Riverside's Chief Information Officer. At a minimum, the IT contracted service will ensure that each organization is able to provide required information to Riverside for management and billing purposes. We have budgeted $32,000 for this IT support for a two month period at $200 per hour. This represents 20 hours a week of technology support.

Please note that Riverside has available software to support our own care management activities and to support Affiliated Partners that wish to use our Netsmart product. There is a nominal cost for expanded used of the product for those AP's that choose to utilize it.

We will provide back-up documentation for expenditures should MassHealth require it.

Year 1 Budget-Operational Infrastructure Investments:

N/A

Years 2-5 Budget-Operational Infrastructure Investments:

N/A

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Section 7.3. H. Sustainability
(Please disregard this section as the content has been substantially changed due to the revision of our budget and budget narrative submitted 12/5/17, as directed, in a separate Excel spreadsheet.)

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7.3.H Sustainability (not to exceed 2 pages) **(Please disregard this section as the content has been substantially changed due to the revision of our budget and budget narrative submitted 12/5/17, as directed, in a separate Excel spreadsheet.)** **The Bidder shall provide a description of its plan to sustainably fund proposed infrastructure and capacity building investments and CP Supports over the Contract Term and after the initial Contract Term. Such description shall include a description of any tools, resources, or processes the Bidder intends to develop using DSRIP funds and continue to maximize after the initial Contract Term.**

Riverside is confident that the BH CP program will be sustainable following the initial Contract Term during which the DSRIP investment has helped to fund infrastructure and capacity building costs. These investments over the course of the initial five years of the program will help ensure the success of Riverside Community Partners including: funds necessary to hire and train staff as caseloads are established and grow; funds necessary for initial equipment; and funds necessary to support software applications.

Hiring and Training Staff:
We plan to utilize DSRIP funds to bring staff on as the project begins and to offset staffing costs over the initial years as the program gains momentum and caseloads fill up. By a sixth year (post initial Contract Term), we have assumed elimination of DSRIP funds. We will have a significant understanding of the number of Enrollees we will be working with and of our staffing needs. The team model we have developed and the DSRIP funds we will have utilized to build the teams while that funding was available will make it possible to operate the program solely on a PMPM rate. We will be well beyond start-up, experienced in the patterns of referrals and of hiring, staff retention in the program and operating a mature program that requires only typical oversight to ensure ongoing excellence of operations.

Utilizing DSRIP funding, staff across Riverside Community Partners (Riverside and our six Affiliated Partners) will be fully trained – with the ongoing exception of newly hired replacement employees, curricula will be created, and additional training will, therefore, be manageable. Policies and procedures will be complete and fully tested and only require review to ensure they are up to date with regulations, practices, and the needs of Enrollees and the program. As noted in the proposal, we will develop both a local and a central resource library for behavioral health and social services and other community supports. Keeping that up to date will require little in the way of resources.

Initial Equipment:
We are utilizing DSRIP funds to purchase equipment (i.e. laptop computers) during the start-up period and during the first year and we have established an ongoing budget that allows us to replace or increase equipment over time. We anticipate having adequate ongoing funding through the PMPM to accommodate our equipment needs in a sixth year and in subsequent years.

Software Applications:
Riverside and our Affiliated Partners have made the decision to utilize existing software to meet our needs both centrally and at the local level. The cost for extending the use of Riverside's own

software to enhance care coordination tracking and documentation is nominal, as is the cost for sharing Riverside's software should an Affiliated Partner wish to use it. Therefore, we do not anticipate this being a significant problem area post DSRIP investments.

Any modifications to the standard software will be made during the early years of the contract and will not require a significant ongoing cost. In particular, we will focus on secure communication between Riverside Community Partners and ACOs/MCOs and our Care Team members. By the end of the initial Contract Term, any such enhancements and modifications will have been developed, tested and in full use.

The Value Proposition:

We believe the value of the BH CP will be proven during the initial five year contract period. The goal of improving collaboration between healthcare and behavioral healthcare and the cost savings that will likely emerge from a more coordinated system of care will provide the foundation for discussions with the ACOs/MCOs on any additional investments needed for BH CPs. We are confident that Riverside Community Partners specifically will have proven its worth and be regarded as a program that the healthcare systems serving MassHealth recipients want to continue to make available to the people they serve. In fact, we believe that the involved ACOs/MCOs are likely to consider expanding the model to include their patients who are funded by private insurance as well. This is largely because through our ability to maintain care coordination relationships with Enrollees over a sustained period of time (the Waiver period), we will have helped individuals who may have been high utilizers of high cost healthcare services to be more engaged in their own preventive care and illness management, reducing the negative effects of chronic disease and preventable hospitalizations and ED visits.

Riverside is committed to working with EOHHS to demonstrate the value of the BH CP program and would be pleased to participate in future discussions with ACOs/MCOs and others as appropriate to ensure continued access to this service for MassHealth recipients beyond the initial Contract Term.

Section 7.3.I Quality Management and Performance Monitoring

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Section 7.3 Initial DSRIP Participation Plan

7.3.I Quality Management and Performance Monitoring (not to exceed 3 pages)
The Bidder shall describe its plans to satisfy the quality management and quality improvement requirements described in Section 2.8 of Attachment A. Such description shall include:

1. A description of the Bidder's quality improvement program

Riverside Community Partners will leverage Riverside Community Care's Quality Management Department's expertize and create additional quality improvement measures specific to the BH CP program. This will enable us to benefit from both professional QM personnel and also put in place ongoing monitoring and support to ensure our BH CP program meets contractual requirements and provides high quality services across all our Affiliated Partners.

Riverside's Quality Management Department is led by Kathleen Janssen, BSN, RN, MS and includes three additional full-time QM staff who collectively provide quality reviews, performance improvement project oversight and more. Our quality improvement program is an ongoing, integrated system that includes many distinct components quality improvement program includes but is not limited to: incident monitoring; client satisfaction surveys; record review and audit system; outcomes management system; goals and objectives setting system accomplished in two-year cycles in support of Riverside's Strategic Plan; CARF international accreditation; and policy development and regular policy review and updates. Our outcomes management system utilizes a variety of different tools as is warranted to effectively measure the array of services Riverside offers to different populations, including adults and children with behavioral health needs, individuals with brain injury and developmental or intellectual disabilities, infants and toddlers with physical, developmental and environmental risk factors and their families. We use validated tools such as the Treatment Outcomes Package (TOP) from Outcome Referrals, Inc. and the Swartz Outcome Scale in BH outpatient and day treatment programs and the Mayo-Portland Adaptability Inventory (MPA1-4) in our programs for people with acquired brain injury, as well as internally developed measurements such as auditing the number of specified treatment goals met at the time of discharge.

Our QM Department collects and analyses the data from all the systems listed above and provides reports to all levels of management. Management is responsible for ensuring the information is shared with program directors and staff. Subsequently, programs make adjustments to their systems and protocols based on data to improve services. One example is our use of data from reports we receive from Outcome Referrals, Inc. Regularly, QM develops a report on aggregated changes in symptomology in each program based on TOP reports, highlighting improvement/significant improvement and when indicated, areas that could be addressed to improve outcomes. The information is shared with program leaders and staff to inform QI efforts. Also at set intervals, QM reviews a sample of clinical records to determine if the client specific TOPS data was used to inform changes in care as indicated by amendments to treatment plans. Another example is our Person Served Satisfaction Survey Process. QM provides management with detailed reports, and at a subsequent QM Oversight Committee meeting, management reports on how the information was shared with and used by program staff. Recently, this data led to programs delving more deeply into the cultures of the people served to better assess culture's impact on their health and well-being. In another example, a program rethought its work flow to find ways to increase face to face time with clients.

As noted, we intend to leverage our experience in QM oversight and resulting QI initiatives to inform our plans for ongoing QM and performance oversight of the BH CP contract. We will enlist Riverside QM department personnel to chair the Quality Committee we will develop for the BH CP program as well as to help with ongoing monitoring. The QM Department will meet with our BH CP Director to provide guidance and to augment her responsibilities in regularly monitoring the records of our BH CP work, such as the routine review of sample records from each Affiliated Partner and from Riverside's BH CP teams to ensure all aspects of the contract responsibilities are occurring and being documented as expected. She will meet with the BH CP team leaders to provide feedback, guidance, problem solve and to encourage the dissemination of best practices across teams. The BH CP Director, with the Medical Director and QM, at minimum will also review critical incidents at least quarterly and will ensure compliance with reporting requirements to ACOs/MCOs and to MassHealth on all required issues (i.e. critical incidents and grievances).Additionally, each of our Affiliated Partners are experienced in QM, and will be responsible for applying their internal performance monitoring system to their BH CP teams, including managing, tracking and reporting to Riverside on any Enrollee complaints (appeals to be reviewed by Riverside's QM Department), as well as participating in ongoing QM processes through the Quality Committee described below.

2. A description of at least one quality initiative the Bidder proposes to undertake in Budget Period 1, including measures for success

We propose to focus our Budget Period 1 quality initiative on measuring the impact of our Care Coordination and Care Management on reduction of visits to hospital Emergency Departments (ED) and inpatient utilization, including visits and admissions for both behavioral healthcare and medical healthcare. This will be accomplished by comparing data from six months prior to participating in the program (baseline) with the first and second six month periods of active engagement in the BH CP.

We are choosing this quality initiative because we believe that Care Coordination and Care Management have the potential to support people with serious behavioral health challenges to better engage in self- care, utilize medical, behavioral and social support systems more effectively and thereby prevent unnecessary trips to the emergency room and the need for hospitalizations for management of acute problems stemming from chronic conditions. To accomplish this, we propose to ask two questions at the time of the Assessment that request that the Enrollee report on the number of ED visits and the number of inpatient admissions they experienced in the 6 months prior to the CP assessment. This data will be collected using a Likert Scale that provides choices including 0 visits, 1-2 visits, 3-5 visits, 5 or more visits and similarly, 0 inpatient admissions, 1-2 admissions, 3-5 admissions, and 5 or more admissions. Ideally, we would not have to rely on Enrollee's self- reporting since actual claims data would be a more accurate baseline. However, since we do not know whether we will have access to prior claims data for Enrollees, we are prepared to utilize the self- reported responses as a baseline for ED visits and inpatient admissions prior to BH CP involvement.

Following six months of active engagement with Care Management, we plan to measure the number of ED visits and inpatient admissions respectively using the same Likert Scale categories. We will seek, however, to utilize utilization data reported by the ACOs/MCOs and or

MassHealth in place of self- reporting, if possible. Otherwise we will utilize data from the electronic BH CP Enrollee record. This same process will at the one year mark. We establish targets as follows: a 10% reduction in ED visits and inpatient admissions during the first 6 month of BH CP engagement and a 15% reduction in ED visits and inpatient admissions during the subsequent six months of engagement. We will define reduction as movement from a higher to lower category on the Likert Scale (i.e. from the 3-5 visits down to 1-2 visits).

We will use a sample size for both measurement periods that reflects a 90% confidence level and a 5% margin of error. Therefore, if our total population of Enrollees who have been actively engaged for the reporting period is 3,000, our sample size will be 247. If the total population is only 1,000, our sample size would be 213. We will most likely use a random sample of Enrollees across all Riverside Community Partners Affiliated Partners regardless of which ACO/MCO they are enrolled in. However, should we determine that one or more of the ACO/MCOs are willing and able to provide us with actual data on ED visits and inpatient admissions, we reserve the right to limit our sampling to those Enrollees for whom we can access that more accurate information.

3. The functions of the Bidder's quality committee, including the composition and reporting structure within the Bidder's organization

Riverside will develop a Quality Committee dedicated to the BH CP program. The Riverside Community Partners Quality Committee will be chaired by Riverside's Vice President for QM or designee, who is an experienced Quality Manager from our QM Department. Riverside's Quality Committee Chair will be responsible for ensuring that the Committee fulfills its QM oversight duties, including deciding on and operationalizing the annual quality improvement initiative, and submitting quality management reports, and the annual quality improvement plan to EOHHS. The Chair will meet with our BH CP Director ahead of committee meetings to hear about any challenges, issues or recommendations for areas of committee focus. The Chair will also be responsible for reporting back to Riverside's leadership on any QM recommendations and/or issues of concern that may arise in the Quality Committee.

Membership of the Quality Committee will include representatives from at least four Affiliated Partners. We will seek to include a person served as well. We intend to schedule Quality Committee meetings quarterly, but it may meet more frequently during the initial year as the program is further developed. However, we recognize that the schedule may be altered by consensus of the committee once operations are actually underway. Minutes will be kept and provided to the Riverside Community Partners Governance Committee.

The Committee will develop and implement the Quality Implementation plan for the BH CP program to ensure an ongoing systematic approach to improving the processes and outcomes of service delivery. Among its areas of focus will be: reviewing and making recommendations in response to the program monitoring activities undertaken and QM reports generated by Riverside's BH CP Director and/or QM Department; determining the annual QI initiative; reviewing data gathered from the QI initiative and ensuring information is used by all Affiliated Partners to inform future operational changes as appropriate; recommending best practices to be shared across teams; and contributing to and reviewing Riverside's quality improvement plan for submission to EOHHS.

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Section 7.3.J Coordination with ACOs and MCOs

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Section 7.3 Initial DSRIP Participation Plan

J. Coordination with ACOs and MCOs (not to exceed 2 pages)

The bidder shall submit a plan for contracting with ACOS and MCOs. Such plan shall include:

1. How the Bidder will communicate its skills, expertise, and value to potential ACOS and MCOs

Riverside and our Affiliated Partners are all core providers of behavioral health and other services in the communities we serve. We have close working relationships with the healthcare organizations that are now ACOs, as well as all MCOs, as a result of our role in these communities and our long history of serving individuals with behavioral health diagnoses. As Riverside Community Partners we will offer locally- based care throughout eleven MassHealth Service Areas. Discussions with many ACOs and MCOs began months ago as the ACO model was being developed and the pilot ACOs were established. These discussions continue today and, in some instances include preliminary agreements to work together.

Once EOHHS has designated the participating ACOs, MCOs and BH CPs, we will meet with all relevant ACOS and MCOs, introduce the ongoing point of contact, distribute printed materials which describe our role as a BH CP, and introduce them to our web presence for Riverside Community Partners. Our printed and web-based materials will include our history and experience working with the BH population as well as describe how we will deliver Community Partner services. It will demonstrate the strength of our model of including Affiliated Partners that have a history of serving very diverse and often underserved individuals.

We will seek to establish protocols between Riverside Community Partners and the MCOs and ACOs which may include but is not limited to:

- Referrals and enrollment procedures
- Methods to ensure that individuals who complete Comprehensive Assessments or Care Plans are not financially or otherwise conflicted
- Communication expectations including bidirectional notification of Enrollee activities
- How participation on the care planning teams will work
- Access to training on care planning tools
- Secure bidirectional electronic communication

A particular challenge will be to ensure that we avoid over-medicalizing care and support whenever possible. Enrollees often have non-medical or social needs that are equally important to ensure in their health, and we intend to seize this opportunity to infuse our care delivery model with community resources that can help our Enrollees access needed services in a coordinated fashion

2. Branding and marketing plans the Bidder has with respect to its relationships with ACOS and MCOs

Our plan is to brand and market both as the trusted local organizations, which are well known and respected in the communities we are serving, and to also leverage our capability as the larger entity, Riverside Community Partners. In most instances, we expect that existing relationships with ACOs and MCOs will continue or develop locally (by Service Area) and that our local presence as Riverside or through each of our six Affiliated Partners will be the key to relationship building. In brief, we believe it is likely that physicians, nurses, other employees, as

well as patients of the ACOs will typically reach out to our local presence. As the larger entity, Riverside Community Partners, we will serve as the accountable organization to MassHealth and the ACOs and MCOs, and accept referrals when it is appropriate to receive them centrally.

3. The Bidders strategy to engage and collaborate with multiple ACOs and MCOs in the Service Areas for which the Bidder is bidding

Riverside and our Affiliated Partners are well known to ACOs and MCOs and we already serve many of the individuals who will receive BH CP support. In anticipation of the RFR's release, we have been meeting with newly identified ACO and MCO bidders to discuss how the CP function can support their patients. As noted above, we have initial agreements with several ACOS and MCOs and continue to meet with them as the process of establishing BH CPs proceeds.

We will establish formal contractual relationships with each ACO and MCO that have overlapping geography with Riverside Community Partners and will utilize any guidance and heed the requirements provided by EOHHS. Once contracting is completed and Enrollee assignment occurs, we will make our best effort to reach out to assigned Enrollees within 30 days and then lead the process of developing a Comprehensive Assessment and Care Plan. Further we will work collaboratively with the ACOs and MCOs to develop policies and procedures for alignment and communication. Our plans include working with Care Management software that will allow us to track and collect relevant data and support seamless care management. We intend to discuss with each ACO or MCO the possibility of establishing bidirectional electronic communication between our care management program and their electronic records to enable information sharing in an efficient manner. We expect that during the initial year of operations, these discussions will be ongoing as the ACO and BH CP operations continue to develop and get increasingly refined.

Our goal will be to formalize these relationships through contracts or agreements that support robust relationships with ACOs and MCOs but that are seamless from the Enrollee perspective. To the extent possible, we plan to standardize our approach to care management but recognize this will take time. Further, we will work to adapt our practices to different cultures and will be aided in this effort by our locally based Affiliated Partners.

One of the significant challenges we will face is to carefully define roles between our Community Partner Services and the ACOs and MCOs. We will work to avoid duplication of effort which would be costly and frustrating to the people we serve.

4. The Bidder's strategy for conflict resolution, should any conflicts arise between the Bidder and an MCO or ACO

As noted above, we will develop formal contracts with each ACO or MCO. These contacts will be comprehensive and include conflict resolution protocols in case of disagreements regarding information flow, patient assignments, quality of care, or other issues. We will encourage conflict resolution at the point of contact and at supervisory levels prior to a review by the Program Director or member of Senior Management.

Community Partner Program Budget Report

Southeast Community Partnership, LLC

Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Estimated Enrollees- Start of Period (All Enrollees)		500	1,000	2,000	3,000	4,000	
Estimated Enrollees - End of Period (All Enrollees)		1,000	2,000	3,000	4,000	5,000	
Estimated Enrollees - Monthly Average (excl CBFS enrollees)		893	1,500	2,500	3,500	4,500	
Estimated Enrollees - Monthly Average (CBFS enrollees only)							
Estimated Program Revenue (excl CBFS enrollees)		$ 1,125,180	$ 3,240,000	$ 5,400,000	$ 7,560,000	$ 9,720,000	$ 27,045,180
Estimated Program Revenue (CBFS enrollees only)		$ -	$ -	$ -	$ -	$ -	$ -
Total Estimated Program Revenue		**$ 1,125,180**	**$ 3,240,000**	**$ 5,400,000**	**$ 7,560,000**	**$ 9,720,000**	**$ 27,045,180**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -	$ -	$ -	$ -
Revenue for Operations		**$ 1,125,180**	**$ 3,240,000**	**$ 5,400,000**	**$ 7,560,000**	**$ 9,720,000**	**$ 27,045,180**

	Program Expenses		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
1	**Salary**		$ 114,250	$ 788,936	$ 2,187,357	$ 3,645,266	$ 5,015,567	$ 6,412,910	$ 18,164,286
2	**Fringe**		$ 22,850	$ 157,787	$ 437,471	$ 729,053	$ 1,003,113	$ 1,282,582	$ 3,632,856
	Total Personnel Costs		$ 137,100	$ 946,723	$ 2,624,828	$ 4,374,319	$ 6,018,680	$ 7,695,492	$ 21,797,142
3	**Training & Professional Development**		$ -	$ 907	$ 2,473	$ 4,066	$ 5,546	$ 7,025	$ 20,017
4	**Travel**		$ 1,603	$ 29,148	$ 82,836	$ 138,060	$ 193,284	$ 248,508	$ 693,439
5	**Equipment**		$ -	$ 1,750	$ 3,000	$ 6,000	$ 6,000	$ 6,000	$ 22,750
6	**Supplies**		$ 1,000	$ 7,813	$ 22,500	$ 37,500	$ 52,500	$ 67,500	$ 188,813
7	**Contract Services** (consulting, professional)		$ -	$ 11,458	$ 33,000	$ 55,000	$ 77,000	$ 99,000	$ 275,458
8	**Software licensing**		$ -	$ 34,325	$ 89,700	$ 140,400	$ 189,000	$ 237,600	$ 691,025
9	**Telecommunications**		$ 2,331	$ 18,214	$ 50,708	$ 83,238	$ 114,478	$ 145,718	$ 414,687
10	**Occupancy** (rent, utilities, maintenance)		$ 3,594	$ 25,156	$ 43,125	$ 86,250	$ 86,250	$ 86,250	$ 330,625
11	**Other**		$ -	$ 69,797	$ 199,115	$ 331,096	$ 461,537	$ 591,978	$ 1,653,523
	Total Direct Costs		$ 145,628	$ 1,145,291	$ 3,151,285	$ 5,255,929	$ 7,204,275	$ 9,185,071	$ 26,087,479
12	**Indirect Cost/Administrative Overhead**	**15.0%**	**$ 21,844**	**$ 171,794**	**$ 472,693**	**$ 788,389**	**$ 1,080,641**	**$ 1,377,761**	$ 3,913,122
	TOTAL EXPENSES		$ 167,472	$ 1,317,085	$ 3,623,978	$ 6,044,318	$ 8,284,916	$ 10,562,832	$ 30,000,601
	Surplus/Shortfall		*$ (167,472)*	*$ (191,905)*	*$ (383,978)*	*$ (644,318)*	*$ (724,916)*	*$ (842,832)*	*$ (2,955,421)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Director of Integration	$ 90,000.00	0.5	7	$ 26,250
Program Director	$ 80,000.00	1	3	$ 20,000
Medical Director	$ 200,000.00	0.1	1	$ 1,667
RN	$ 76,000.00	2	1	$ 12,667
LPN	$ 54,000.00	1	1	$ 4,500
Clinical Care Manager (LICSW/LMHC)	$ 68,000.00	1	2	$ 11,333
Care Coordinator	$ 43,000.00	9	1	$ 32,250
Recovery Coach/Peer Specialist	$ 35,000.00	1	1	$ 2,917
Administrative Assistant	$ 32,000.00	1	1	$ 2,667
Total Salary (Program Budget Line 1)		**16.6**		**$ 114,250**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 114,250	20%	$ 22,850
Total Fringe (Program Budget Line 2)			**$ 22,850**

Total Personnel*	**$ 137,100**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

Director of Integration will oversee community partners program, including contracting, program operations, marketing, and finance.

Program Director will assume administrative responsibility for meeting staffing, programmatic, financial, regulatory and contractual requirements.

Medical Director will provide consultation to nurses and treatment team, as well as to PCP.

Registered Nurses will provide medication reconciliation, assessment and treatment planning, PCP coordination and health education.

Licensed Practical Nurses will provide care coordination with medically complex cases, medication reconciliation and coordination with medical providers.

Clinical Care Managers will approve comprehensive assessment, and provide treatment planning and treatment plan review, clinical supervision and oversight of the clinical team.

Care Coordinators will provide outreach, engagement, assessment, treatment planning, recovery navigation, care transitions, crisis planning and health and wellness coaching.

Recovery Coaches/ Peer Specialists will provide care coordination for substance use disorders, including access to support services, and care transitions.

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Total Training and Professional Development (Program Budget Line 3)			

Provide a description of each Training and Professional Development line item included in the table above:

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
Planning, Implementation, and Operations Committee				$ 1,603.00
				$ -
			Total Mileage	$ 1,603.00

Travel Expense Description	Cost
Total Mileage	$ 1,603.00
Parking and tolls	
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ 1,603.00**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

The Planning, Implementation, and Operations Committee is comprised of the leadership team of the CP, from Gosnold, FCP and SSMH. The Committee includes the Director of Integration (whose compensation is not countedin the CP Leadership Team line item for Operational Staffing, as it is already included in the program budget, but whose mileage is counted here). The CP Leadership Team meets regularly for coordination between Gosnold, FCP, and SSMH, and will drive strategy, monitor progress, and ensure clear communication throughout the CP. The weekly operation meeting will be held in Plymouth, and the monthly LLC meeting will be held in Quincy. The committe will include 6 people, 2 based in Quincy, 2 based in Plymouth, and 2 based in Falmouth.

Mileage for the weekly operations meeting in Plymouth is 4 people * 60 miles round trip (both Quincy and Falmouth are approximately 30 miles from Plymouth) * 3 trips per month * 7 months * .48 per mile = $2,419.

Mileage for the monthly LLC meeting in Quincy is (2 people from Plymouth * 60 miles round trip * 1 trip per month * 7 months * .48 per mile) + (2 people from Falmouth * 120 miles round trip * 1 trip per month * 7 months * .48 per mile) = $403 + $806 = $1,209

Total estimated mileage: $2,419 + $1,209 = $3,628

Row 5 - Equipment

Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost
Total Equipment (Program Budget Line 5)			

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Supplies			$ 1,000.00
Total Supplies (Program Budget Line 6)			

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

By June 1, 2018, a total of 18 staff will be hired. Roughly $1,000 is budgeted to cover all office essentials, i.e. copying/printing paper, legal pads, pens, etc.

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
		Total Software Licensing (Program Budget Line 8)	

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Ring Central Subscription	11	26	$ 282.00
iPhone Plan	50	24	$ 1,205.00
MiFi Subscription for iPad	35	24	$ 844.00
		Total Telecommunications (Program Budget Line 9)	**$ 2,331.00**

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

RingCentral is a cloud-based communications and collaboration tool that allows the Clinical Care Managers, Care Coordinators and Recovery Specialists to bring a client and other care team members into conference by phone or video.

iPhone plans provide staff with full accessibility, allowing them to continue supporting clients even while mobile.

The MiFi subscriptions for the iPads will provide internet connectivity for staff at all times, facilitating their ability to have full and secure access to records and resources within clients' homes.

Together, these telecommunications tools provide enhanced mobility and flexibility, improving client experience and continuity of care.

All costs are estimated based on prices in existing contracts. Costs per service plan listed above are on a monthly basis. Number of service plans refer to number of FTE with plans multiplied by number of months these staff hold the plans.

The "# Service Plans" refers to the number of per-staff per-month payments (and the cost per service plan refers to the monthly amount). For example, the .5 FTE Director of Integration will work for seven months during the PBP (November –

May), and thus has 3.5 (7 *.5) 'service plans' attached.

Position	FTEs	# Months	Number of RingCentral Subscription Monthly Payments	Number of MiFi Subscriptions & iPhone Plan Monthly Payments
Director of Integration	0.5	7	3.5	3.5
Program Director	1	3	3	3
Medical Director	0.1	1	0.1	0.1
RN	2	1	2	2
LPN	1	1	1	1
Clinical Care Manager (LICSW/LMHC)	1	2	2	2
Care Coordinator	9	1	9	9
Recovery Coach/Peer Specialist	1	1	1	1
Administrative Assistant*	1	1	1	
Program Budget Staffing Subtotal:	**16.6**		**22.6**	**21.6**
Project Mgr/ System Administrator	0.5	5	2.5	2.5
Help Desk - Tier 1*	0.5	1	0.5	
Infrastructure Staffing Subtotal:	**1**		**3**	**2.5**
Total	**18**		**26**	**24**

* Administrative Assistant and Help Desk - Tier 1 will have RingCentral subscriptions, but not MiFi subscriptions or iPhone plans.

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent	1,500	2.08	$ 3,125
Utilities	1,500	0.21	$ 313
Repair and Maintenance	1,500	0.10	$ 156
Total Occupancy (Program Budget Line 10)			**$ 3,594**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

The occupancy costs will cover 5 locations, serving as hubs throughout the Southeast region, and housing the workspaces for staff when they are in the office.

Costs were calculated for one month, as the CP will begin leasing the spaces in May 2018, thus for one month of the PBP. Annual costs per square foot would be 12 times what is shown above, i.e. $25/ sq ft for rent.

The amounts for Utilities, and Repair and Maintenance (including Janitorial Services) were calculated as a proportion of rent, using comparable existing programs as a basis for calculation.

Row 11 - Other

Other Direct Expense Description	Cost
	$ -
Total Other (Program Budget Line 11)	**$ -**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	**15.00%**	**$ 21,844**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

For CP budgets, we adopted 15% administrative overhead rate, which is the lesser between our actual rate and the allowed rate per CP budget guidance.

Community Partner Infrastructure Budget Report

			Southeast Community Partnership, LLC						
	Infrastructure Investment Funding		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
	PMPM Infrastructure Rate			$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
	Engaged Enrollees			1,000	1,000	2,000	3,000	4,000	
	Estimated Infrastructure Funds			$ 700,000	$ 1,032,600	$ 1,235,760	$ 1,634,400	$ 1,885,440	**$ 6,488,200**
	At- Risk Withhold Rate				25%	44%	63%	81%	
	Withhold				$ 258,150	$ 543,734	$ 1,029,672	$ 1,527,206	**$ 3,358,763**
	TOTAL MAXIMUM FUNDS AVAILABLE		$ 450,000	$ 700,000	$ 774,450	$ 692,026	$ 604,728	$ 358,234	**$ 3,579,437**
	Infrastructure Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
	Technology								
1	**IT Staffing including Fringe**		$ 25,215	$ 48,404	$ 100,516	$ 138,835	$ 169,757	$ 199,108	**$ 681,835**
2	**Development Adaptation of EHR and/or Care Management System**		$ 90,000	$ 95,000	$ 50,000		$ 25,000	$ -	**$ 260,000**
3	**Technology for Service Delivery**		$ 28,008	$ 39,151	$ 32,964	$ 88,122	$ 86,606	$ 74,646	**$ 349,497**
4	**Other Technology Expenses**		$ -	$ 50,000	$ -	$ -	$ -	$ -	**$ 50,000**
	Total Technology		$ 143,223	$ 232,555	$ 183,480	$ 226,957	$ 281,363	$ 273,754	**$ 1,341,332**
	Workforce Development								
5	**Workforce Development staffing including Fringe**		$ 37,497	$ 17,094	$ 20,315	$ 93,662	$ 109,955	$ 34,573	**$ 313,096**
6	**Recruitment Expenses**		$ 12,569	$ 10,048	$ 8,472	$ 12,945	$ 12,308	$ 12,308	**$ 68,650**
7	**Training Expenses**		$ 1,658	$ 2,597	$ 1,356	$ 3,412	$ 2,519	$ 2,519	**$ 14,061**
8	**Retention Expenses**		$ -	$ 16,100	$ 13,314	$ 19,427	$ 18,400	$ 18,400	**$ 85,641**
	Total Workforce Development		$ 51,724	$ 45,839	$ 43,457	$ 129,446	$ 143,182	$ 67,800	**$ 481,448**
	Business Start Up Costs								
9	**Office Equipment (PBP & BP1 only)**		$ -	$ -					**$ -**
10	**Office Furniture (PBP & BP1 only)**		$ 15,429	$ 98,659					**$ 114,088**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**		$ 167,472	$ 191,905	$ 383,978	$ 644,318			**$ 1,387,673**
	Total Business Start Up Costs		$ 182,901	$ 290,564	$ 383,978	$ 644,318			**$ 1,501,761**
	Operational Infrastructure								
12	**Operation Staffing including Fringe**		$ 26,200	$ 59,347	$ 99,604	$ 99,971	$ 100,342	$ 100,716	**$ 486,180**
13	**Other Operational Expenses**		$ 9,101	$ 5,422	$ 13,000	$ 13,000	$ 13,000	$ 13,000	**$ 66,523**
	Total Operational Infrastructure		$ 35,301	$ 64,769	$ 112,604	$ 112,971	$ 113,342	$ 113,716	**$ 552,703**
14	**Indirect Cost/Administrative Overhead Rate**	15.0%	$ 36,851	$ 66,273	$ 50,931	$ 70,406	$ 80,683	$ 68,291	**$ 373,435**
	TOTAL INVESTMENTS		**$ 450,000**	**$ 700,000**	**$ 774,450**	**$ 1,184,098**	**$ 618,570**	**$ 523,561**	**$ 4,250,679**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Project Mgr/ System Administrator	$ 80,000.00	0.5	5	$ 16,667
Help Desk - Tier 1	$ 55,000.00	0.5	1	$ 2,263
IT Contractor (salary reflects full-time at contract rate of $50/hr); fringe excluded for this position)	$ 100,000.00	0.1	3	$ 2,500
	Total Salary			$ 21,429
	Fringe rate	20.0%	Total Fringe	$ 3,786
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 25,215**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

IT Project Mgr/System Administrator will lead efforts on design, configuration and implementation of the Care Manager solution. They will be responsible for the development of standard operating procedures and implementing workflows. By leading the design and optimization of the system, they will maximize its value to clinical staff in their work to serve our clients.

The Help Desk position will provide Tier 1 technology support to program staff, including for their use of the Care Management Platform, enabling them to maximize the value provided to clients.

The IT Contractor will perform the laptop and iPad builds and iPhone provisioning (MDM enrollment) for program staff, ensuring that they are ready to provide services for our enrollees.

Row 2 - Development/Adaptation of EHR and/or Care Management System

	A	B	C	D	E	F	G
31	**Description of Expense**	**Cost**					
32	CMP Development & Implementation	$ 90,000.00					
33							
34							
35							
36	**Total Development and Adaptation of EHR and Care**						
37	**Management System**	$ 90,000.00					
38	**(Infrastructure Budget Line 2)**						
39							
40	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
41	***contract and how the costs were determined:***						
42							
43	The Care Management Platform will assist in identifying client needs thereby promoting greater engagement. The solution will also						
44	enable the electronic transmission of clinical and care information between provider systems and include numerous other						
45	interoperability features. Patients can communicate with staff through a patient portal, which will facilitate the patients providing						
46	information and documentation to their care team in a timely manner and via a secure path. All of these features will enable staff						
47	to provide integrated, client-centric care in a highly effective manner.						
48							
49	Costs were estimated through ongoing discussions with Care Management System vendors. This cost estimate is 50% of the total						
50	estimated cost because it is our intent to implement one Care Management Platform (CMP) for two CP contracts.						
51							
52							
53							
54							
55							
56							
57	**Row 3 - Technology for Service Delivery**						
58	**Description of Expense**	**Cost**					
59	Laptops	$ 12,608.00					
60	Mobile toolkit (iPad, mobile printer, keyboard and Bluetooth)	$ 15,400.00					
61							
62							
63							
64	**Total Technology for Service Delivery**	**$ 28,008.00**					
65	**(Infrastructure Budget Line 3)**						

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

iPads, mobile printers , and iPad keyboard and Bluetooth setups allow our clinical staff to be 100% mobile for full service delivery on the go. Laptops will be purchased for supervisory staff (nurses and clinical care managers will have both laptops and mobile toolkits), as well as office-based staff (Admin Assistant and IT staff who will only receive laptops).

Laptop, including 4 years of hardware coverage ($1553 each) + Microsoft Office license ($76) + Laptop bag ($30 each) = $1,659 each $1,659 * 7.6 = $12,608
iPad ($500 each) + Mobile printer ($400 each) + iPad keyboard + bluetooth ($200) = $1,100 each
$1,100 * 14 = $15,400

Laptops will be purchased for the below newly hired positions in both the Program Budget and the Infrastructure Budget. For fractional FTE's, the staff person will be allocated between this program and other program(s), and so the costs of their technology will be allocated proportionally. Mobile toolkits willl purchased only for clinical staff.

Position	FTEs	Number of Laptops	Number of Mobile Toolkits
Director of Integration	0.5	0.5	
Program Director	1	1	
Medical Director	0.1	0.1	
RN	2	2	2
LPN	1	1	1
Clinical Care Manager (LICSW/LMHC)	1	1	1
Care Coordinator	9		9
Recovery Coach/Peer Specialist	1		1
Administrative Assistant	1	1	
Program Budget Staffing Subtotal:	**16.6**	**6.6**	**14.0**
Project Mgr/ System Administrator	0.5	0.5	
Help Desk - Tier 1	0.5	0.5	

	A	B	C	D	E	F	G
98	**Infrastructure Staffing Subtotal:**	**1.0**	**1.0**	**0.0**			
99	**Total**	**17.6**	**7.6**	**14.0**			
100							
101							
102							
103	**Row 4 - Other Technology Expenses**						

104	**Description of Expense**	**Cost**
105		
106		
107		
108	**Total Other Technology Expenses**	
109	**(Infrastructure Budget Line 4)**	

110

111 ***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***
112 ***contract and how the costs were determined:***

113
114
115
116
117

118

119 Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

120

121 **Row 5 - Workforce Development Staffing including Fringe**

122	**Position**	**Annual Salary**	**FTEs**	**# Months**	**Total**
123	Director of Recruiting	$ 80,000.00	0.20	5	$ 6,619
124	Recruiters	$ 57,000.00	0.20	4	$ 3,800
125	HR Coordinator	$ 36,000.00	0.05	4	$ 600
126	Payroll Manager	$ 65,000.00	0.04	2	$ 433
127	Director of Benefits	$ 80,000.00	0.04	2	$ 533
128	Credentialing - Standard	$ 54,000.00	0.35	3	$ 4,725
129	Credentialing - Advanced	$ 75,000.00	0.02	3	$ 375
130	Director of Training	$ 93,000.00	0.25	7	$ 13,563

	A	B	C	D	E	F	G
131	Training Assistant	$ 36,000.00	0.10	2	$ 600		
132							
133							
134							
135		Total Salary	1.25		$ 31,248		
136		Fringe rate	20.0%	Total Fringe	$ 6,250		
137	**Total Workforce Development Staffing including Fringe**				**$ 37,497**		
138	**(Infrastructure Budget Line 5)**						
139							
140	***For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting***						
141	***the terms of the CP's contract:***						
142							
143	The Director of Recruiting will drive the job posting and advertising functions, including attending job fairs, etc, and will also take						
144	part in the review, screening, and hiring of candidates. The Recruiters and HR Coordinator will perform all functions related to						
145	reviewing, screening, and hiring candidates. Together these staff will ensure that our programs are fully staffed with top						
146	employees, who will provide excellent care to our clients.						
147							
148	The Payroll Manager will complete all set-up processes required in both internal and external payroll systems. The Director of						
149	Benefits will complete all required processes pertaining to new employees' benefits, including health insurance and retirement accounts. The Standard Credentialing staff will communciate with new employees and vendors regarding new employees' credentialing; gather all relevant documentation and resolve any inconsistencies therein; and enter all information in appropriate systems. The Advanced Credentialing staff will determine privileges as appropriate for incoming employees. Together these staff will ensure that all new hires are smoothly and effectively on-boarded so that they can work to serve our clients without disruption.						
150							
151	The Director of Training will research and develop training materials and train newly hired staff. The Training Assistant will						
152	perform all logistical work required for trainings, including compilation of training materials, room set-up, and e-learning license						
153	registration. Together these staff will ensure that all staff serving our clients are fully trained and ready to provide our clients with high-quality care.						
154							
155	The positions listed do represent allocations of actual resources. Of all positions listed, only training curriculum development						
156	(part of the Director of Training's responsibility) will be a centralized function performed by SSMH. Thus, part of the funding for						
157	the Director of Training is allocated 100% to SSMH, and part of this position's funding, as well as all of the funding for all						
158	remaining positions ,is allocated based on the estimated number of engaged clients among Gosnold, SSMH and FCP (i.e. Gosnold,						

Row 6 - Recruitment Expenses

Description of Expense	Cost
Advertising	$ 5,100.00
Referral & Signing Bonuses	$ 2,882.00
SORI Checks	$ 882.00
Badges & Payroll System Set-up	$ 3,705.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 12,569.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Advertising entails sponsorships on sites such as Glassdoor and Indeed, use of Open Hire and various recruiting websites, postings at local universities and newspapers, and attendance at job fairs. Costs were estimated based on existing job advertising expenses. We are planning that during the PBP, we will spend $1500 on sponsoring a page at Glassdoor, $1400 for an Indeed sponsorship, $600 for OpenHire, $100 for college/university postings, $750 for advertisements in local papers and print advertisements, $250 for advertising on other websites, and $500 at job fairs. In some cases, one advertisement may be used for positions in multiple programs (for example in different CP contracts). In these cases, the costs listed reflect a proportional allocation of the total estimated cost.

Referral bonuses are bonuses given to current employees who refer successful candidates for hire. Costs were estimated based on typical percentages of new hires who are hired through referrals. Referral bonuses are $250 each; we have estimated that 1/5 of new hires will be through referrals. Costs were determined based on 17.6 FTE's of new hires during the PBP (all program positions, with the addition of Project Mgr/ System Admin and Help Desk). Signing bonuses are bonuses given to RN's who are hired, and are calculated based on the anticipated number of newly hired RN's. Signing bonuses are for RN's (2 to be hired during the PBP), and are $1000 for each RN.

SORI checks are checks as to whether a job candidate has a record of Sex Offense convictions. Costs are estimated based on the number of employees that will be hired.

Together these expenses will ensure that our program is staff with highly qualified employees who will provide our clients with excellent care.

excellent care.

The creation of organization badges and payroll system set-up fees (paid to external payroll system vendors) ensure that newly

Row 7 - Training Expenses

Description of Expense	Cost
Supplies (including food) for Orientation	$ 494.00
E-Learning Licenses & Training Supplies	$ 1,164.00
Total Training Expenses (Infrastructure Budget Line 7)	**$ 1,658.00**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Supplies for Orientation include printed materials and food served to new employees during Orientation. E-Learning Licenses allow new employees to access training located on our E-Learning system (an external system containing both internally and externally created training materials). Training supplies include the cost of printed training materials, as well as any other costs required for training. Together these expenditures will allow our new employees to be effectively on-boarded and trained.

Costs are determined based on existing Orientation and Training supply costs.

Row 8 - Retention Expenses

Description of Expense	Cost

	A	B	C	D	E	F	G
215	**Total Retention Expenses**						
216	**(Infrastructure Budget Line 8)**						
217							
218	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms***						
219	***of the CP's contract and how the costs were determined:***						
220							
221							
222							
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226							
227							
228							
229							
230	**Community Partner <u>Infrastructure</u> Budget Report - Business Start Up Costs - Prep Budget Period**						
231							
232	**Row 9 - Office Equipment**						
233	Description of Expense	Cost					
234							
235							
236							
237							
238	**Total Office Equipment**						
239	**(Infrastructure Budget Line 9)**						
240							
241	***Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were***						
242	***determined:***						
243							
244							
245							
246							

Row 10 - Office Furniture

Description of Expense	Cost
Furniture	$ 15,429.00
Total Office Furniture (Infrastructure Budget Line 10)	**$ 15,429.00**

Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:

Office furniture will be procured to set up the 5 office hubs for the inital wave of staff hiring.

Total costs are based on estimated $900 per staff person (desk, chair, file cabinet) x 17.1FTE's of initial hires (new furniture is not being purchased for the Director of Integration). Furniture will be purchased for the below newly hired positions in both the Program Budget and the Infrastructure Budget. For fractional FTE's, the staff person will be allocated between this program and other program(s), and so the costs of their furniture will be allocated proportionally.
For fractional FTE's, the staff person will be allocated between this program and other program(s), and so the costs of their

Position	FTEs	
Director of Integration		New furniture will not be purchased for the Director of Integration
Program Director	1	
Medical Director	0.1	
RN	2	
LPN	1	
Clinical Care Manager (LICSW/LMHC)	1	
Care Coordinator	9	

	A	B
279	Recovery Coach/Peer Specialist	1
280	Administrative Assistant	1
281	**Program Budget Staffing Subtotal:**	**16.1**
282		
283	Project Mgr/ System Administrator	0.5
284	Help Desk - Tier 1	0.5
285	**Infrastructure Staffing Subtotal:**	**1**
286	**Total**	**17**

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Marketing Staff	$ 45,000.00	0.4	2	$ 3,000
Quality Assurance Analyst	$ 60,000.00	0.3	1	$ 1,500
CP Leadership Team	$ 100,000.00	0.3	7	$ 17,500
	Total Salary	1		$ 22,000
	Fringe rate	20.0%	Total Fringe	$ 4,200
			Total Program Staffing including Fringe (Infrastructure Budget Line 12)	**$ 26,200**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

The Marketing Staff will prepare the marketing materials and strategies that will drive our outreach to attributed clients, to increase their awareness of and engagement with our services.

The Quality Assurance Analyst will review program data and metrics regarding quality of care indicators, measurement and

outcomes. This will help to ensure that our clients are receiving excellent services, and engage in continuous improvement measures to drive ever increasing quality of care.

The CP Leadership Team (annual salary listed is an average) will meet regularly for planning purposes and for coordination between the SSMH, Gosnold, and FCP. The CP Leadership Team will drive strategy, monitor progress, and ensure clear communication throughout the CP. The Director of Integration's time is not included here, as this position is included in the program budget.

Row 13 - Other Operational Expenses

Description of Expense	Cost
Legal Fees	$ 1,351.00
Marketing & Branding Expenses	$ 7,750.00
Total Other Operational Expenses (Infrastructure Budget Line 13)	**$ 9,101.00**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Legal consultation is anticipated to address various contracting issues, whether with ACOs/MCOs and between partners, as well as any other legal consultation needs. No budgeted legal costs will be used to contract with EOHHS.

Marketing and branding expenditures will support the development of the first batch of materials that will be distributed to our attributed clients, to increase their awareness of our program. Costs were estimated as follows:
Brochures: $3,020 for brochures
Food gift card to incentivize Member participation – $5 x 750 = $3,750
Direct mail campaign: $0.49 x 1,000 x 2 = $980

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**15.00%**	**$ 36,852.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

For the CP budgets, we adopted 15% administrative overhead rate, which is the lesser between our actual rate and the maximum allowed rate per CP budget guidance.

Community Partner Infrastructure Allocation Worksheet

	Southeast Community Partnership, LLC						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 700,000	$ 774,450	$ 692,026	$ 604,728	$ 358,234	$ 3,579,437
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Gosnold on Cape Cod	$ 14,005	$ 39,576	$ 16,482	$ 44,060	$ 42,334	$ 25,537	$ 181,994
FCP, Inc.	$ 7,002	$ 19,788	$ 8,241	$ 22,031	$ 21,167	$ 12,769	$ 90,998
SSMH, Inc.	$ 122,216	$ 173,191	$ 158,757	$ 160,866	$ 211,566	$ 149,003	$ 975,599
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ 143,223	$ 232,555	$ 183,480	$ 226,957	$ 275,067	$ 187,309	$ 1,248,591
Workforce Development							
Gosnold on Cape Cod	$ 18,118	$ 21,799	$ 21,252	$ 63,420	$ 69,125	$ 22,591	$ 216,305
FCP, Inc.	$ 9,060	$ 10,900	$ 10,626	$ 31,711	$ 34,562	$ 11,295	$ 108,154
SSMH, Inc.	$ 24,546	$ 13,140	$ 11,579	$ 34,315	$ 36,292	$ 12,505	$ 132,377
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ 51,724	$ 45,839	$ 43,457	$ 129,446	$ 139,979	$ 46,391	$ 456,836
Business Start Up Costs							
Gosnold on Cape Cod	$ 91,450	$ 145,282	$ 191,990	$ 76,123	$ -	$ -	$ 504,845
FCP, Inc.	$ 45,725	$ 72,641	$ 95,994	$ 38,061	$ -	$ -	$ 252,421
SSMH, Inc.	$ 45,725	$ 72,641	$ 95,994	$ 38,062	$ -	$ -	$ 252,422
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ 182,900	$ 290,564	$ 383,978	$ 152,246	$ -	$ -	$ 1,009,688
Operational Infrastructure							
Gosnold on Cape Cod	$ 41,127	$ 69,394	$ 82,087	$ 91,916	$ 94,973	$ 62,294	$ 441,791
FCP, Inc.	$ 14,838	$ 24,863	$ 27,043	$ 31,958	$ 33,800	$ 21,568	$ 154,070
SSMH, Inc.	$ 16,188	$ 36,785	$ 54,405	$ 59,503	$ 60,909	$ 40,672	$ 268,462
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ 72,153	$ 131,042	$ 163,535	$ 183,377	$ 189,682	$ 124,534	$ 864,323
TOTAL INVESTMENTS	$ 450,000	$ 700,000	$ 774,450	$ 692,026	$ 604,728	$ 358,234	$ 3,579,438

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	IT Staffing inlcuding Fringe	Recruit, hire, train Project Mgr/System Administrator to support CP Program	11/01/17	03/31/18	Onboarding of IT PM/System Administrator	Hiring and onboarding complete			Hiring of sufficient IT staff	IT Project Mgr/System Administrator prepared for operations		
Technology	IT Staffing inlcuding Fringe	Set up IT Help desk for Care Management Platform	01/01/18	05/31/18	Hiring of IT staff for Help Desk	Hiring complete			Help desk ready for operations	Help Desk ready for Go-Live		
Technology	Development and Adaptation of E.H.R/Care Management System	Procure, install, and test Care Management Platform. Train key staff on use of Care Management Platform.	07/01/17	03/31/18	Care Management Platform installed and tested. Key staff (including IT Project Mgr and Director of Training) trained on Care Management Platform.	Successful installation			Care Management System passed all readiness testing.	Care Management System ready for operations Go-Live		
Technology	Technology for Service Delivery	Acquire and prepare mobile technology such as laptops, printers, cell phones, for first wave of staff	01/01/18	03/31/18	Technology prepared for testing	Technology ready for testing			Technology ready for field operations	Technology distributed to staff and ready for Go-Live		
Workforce Development	Workforce Development Staffing including Fringe	Recruit initial staffing and develop workforce strategy for CP Program growth	07/01/17	05/31/18	Advertising, job fairs, and networking underway. Hiring of initial staffing for startup.	Hiring of initial program staff complete.			Sufficient program staff deployed in field. All operations staff deployed	Staffing sufficient to meet anticipated program enrollment at onset		
Workforce Development	Workforce Development Staffing including Fringe	Develop standardized orientation and recurring BBHCP modules, based on care model	11/01/17	03/31/18	Standardized curriculum	Curriculum that reflects key elements of care model						
Workforce Development	Recruitment Expenses	Implement recruitment strategy	11/01/17	05/31/18	Advertising, job fairs, and networking underway. Hiring of initial staffing for startup.	Hiring of initial program staff complete.			Sufficient program staff deployed in field. All operations staff deployed	Staffing sufficient to meet anticipated program enrollment at onset		
Workforce Development	Training Expenses	Train all first wave program, IT, and admin staff	02/01/18	05/31/18	Training and orientation program ready	Training and orientation materials prepared			Staff training complete (for first wave of staff)	Documentation of training completed by all first wave staff		
Business Start Up Costs	Office Furniture	Procure office furniture and prepare all program sites to support operations	02/01/18	05/31/18	All program sites will have sufficient furnishings to support staff and operations	All sites have sufficient space, furnishings, to support staff			Office sites will support initial staffing and anticipated program growth	All initial staff deployed at sites		
Operational Infrastructure	Operation Staffing including Fringe	Marketing and branding, outreach to stakeholders	11/01/17	05/31/18	Contracting, marketing and outreach to ACO's, MCO's, LTSS, hospitals, PCP's	Marketing and outreach to stakeholders is launched			Working relationships established with key stakeholders	Documentation of incipient relationships with key stakeholders		

BH Community Partner - Staffing Model

Southeast Community Partnership, LLC

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	1000	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	1.5	*Total management oversight of BH CP*
3	Medical Director	0.1	*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs	3	
5	Clinical Care Managers (RN)	1	*Do not include FTEs listed in line 4*
6	Clinical Care Managers (LPHA)	2	*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders		*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff		*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	18	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)	2	*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists		
12	Administrative Support	1	
13			
14	Total FTE	28.6	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1:250	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	1:6	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff: care coordinators will be supervised both by the Clinical Care Managers (LPHA) and the RN's

Section 7.3 Initial DSRIP Participation Plan

7.3.A Executive Summary

1. Goals, identified challenges related to the care delivery system and behavioral health, and proposed solutions to be effectuated through the CP program

The SCP BH CP Team has a long history of providing comprehensive BH services in the Southern Region. The Team has developed a number of strategies to address the challenges of a large, diverse, and complex service delivery system. Given that the region is comprised of 12 service areas, the Team will develop five geographically based Hubs, located at current licensed BH clinic sites. The Hyannis Hub will cover the Barnstable and Orleans. The Falmouth Hub will cover Falmouth, Nantucket and Oak Bluffs. The Plymouth Hub will cover the Plymouth and Wareham. The North Dartmouth Hub will cover Fall River and New Bedford. The Stoughton Hub will cover Brockton, Taunton and Attleboro. Each Hub will have a comprehensive, care management team. The Hubs are each located at licensed mental health clinic sites with full complement of clinical support services and a network of relationships with the local service systems. The Team's structure supports our ability to fulfill all contract requirements, including:

- Seasoned executive and senior team, with experience in a variety of inpatient, outpatient, residential, and other community-based models, including CSP and CBFS;
- Human Resources and Training Departments to support onboarding, orientation, and professional development needs of the LLC;
- Robust QM, Risk Management, Health IT, Health Records, and Billing Departments, which encompass a team of professionals in each discipline who will work to establish quality data systems to capture, monitor, and report contract metrics and outcomes; to ensure service delivery documentation and billing submissions align; and to drive QI as needed.
- Fully integrated EHR with sophisticated Health Information Teams, with significant Application and Structure Query Language (SQL) competencies.

The SCP BH CP Team will work to solidify current relationships and develop new ones with ACOs, hospital systems, PCPs, Federally Qualified Health Clinics (FQHCs), BH providers, state agencies, advocacy groups, ESPs, law enforcement, courts, and other organizations that are key to BH and medical integration. The SCP BH CP Team has extensive experience with care management models including CSP, Recovery coaches, REACH program and Here-for-You, which will inform the development of the proposed care coordination model. Communication and coordination of services across the region and service areas will be enhanced with technology including a shared Care Management Platform, interoperability through the Mass HIway, applications to enhance health, wellness and integration of care with medical providers.

The SCP BH CP Management Team will ensure that the five Hubs utilize uniform policies, procedures, training, staffing, supervision, and quality management. A major challenge for the BH CP Team will be workforce development to recruit, hire, train and supervise staff in service areas that have been historically difficult to staff, such as Nantucket, Martha's Vineyard, Fall River and New Bedford. In addition, cultural and language capacity will be essential in providing services in such a diverse region. The BH CP Team will utilize its existing experience and connections to the communities it serves to develop a culturally diverse workforce.

2. Number of Assigned and Engaged Enrollees the Bidder intends to support under the Contract.

The BH CP will support a minimum of 1,000 enrollees throughout the Southern Region Service Area. Our design of five Hubs accommodate a scale-up goal to serve a total of 5,000 Engaged Enrollees by Budget Year 5. Enrollees are individuals with high risk and need with chronic medical and BH conditions, including SPMI, SUD, and co-occurring disorders. The BH CP will engage in targeted outreach strategies to address historically hard to reach clients and those facing numerous challenges relating to their social determinants of health. The BH CP will seek to address the highest need and cost individuals through a comprehensive, wraparound approach that is individualized, culturally competent, and designed to achieve better health outcomes.

3. The Service Areas for which the Bidder is bidding.

The SCP BH CP Team, which includes SSMH, Gosnold and FC, will operate in the entire Southern Region Service Area, including Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oak Bluffs, Orleans, Plymouth, Taunton, Wareham.

4. Plans to operationalize the CP program and associated time frames

During the Preparation Budget Period, the SCP BH CP Team will write policies and procedures for the program, which will include developing the aforementioned committees. These committees will be essential in developing the program as well as continuing to ensure that the needs of Engaged Enrollees and the program quality are held to a high standard. The BH CP Team will utilize the planning period to develop and execute a strategic plan for workforce development and training. The current shortage of qualified staff and the competition for those staff will be addressed through development of an internal recruitment and training program. Staff will be recruited and trained prior to operational start-up utilizing DSRIP funding. Staffing will be ramped up to serve the growing numbers of Enrollees. The BH CP will provide trainings in a didactic format for all newly hired staff with annual trainings to promote continued staff development. The training modules will be videotaped and added to Relias Learning to establish a standardized training package. The SCP BH CP will maintain and expand relationships with contracting ACOs during the planning period. Negotiations have begun with Boston Medical Center's (BMC) ACO through South Shore Hospital (SSH) and Signature Health, and Steward Health's ACO and its associated hospitals, Cape Cod and Good Samaritan. These ACO linkages will prepare the CP to identify and engage Enrollees. Gosnold will provide ESP service in Nantucket through a sub-contract with BMC. The Team will establish other relationships to provide ESP services. During the budget preparation period, a Care Management Platform will be implemented. The CP will establish a plan, quality indicators, and program evaluation system.

Year 1-5

- The Management Committee will meet regularly to provide program oversight, and the CAC and LQTM will meet quarterly to review Enrollee concerns, outcomes data, and quality.
- The BH CP Team will conduct regular trainings for new staff on topics such as engagement, documentation and community resources. In addition, staff will also be asked to participate in periodic trainings conducted by EOHHS or its designee, including trainings that cover various aspects of MassHealth payment reform, including ACOs and/or CPs initiatives.
- The SCP BH CP Team views community relationships and collaborations to be an essential component of the BH CP, and significant efforts will be taken to preserve these throughout.
- The BH CP will engage Enrollees using EBPs and community resources.
- The BH CP will collect and analyze data to inform BH CP services, making QI as needed.

7.3.B Supporting Populations and Community Engagement

1. Connections to the Community

The SCP BH CP Team has strong community connections throughout the entire Southeast Region Service Region. Together, SSMH, Gosnold, and FC have deep collective experience covering Service Areas from Fall River to Taunton, Attleboro, and Brockton, and southward to Plymouth, and then down to Cape Cod and the Islands. These longtime community connections as well as our diversified service reach and deep relationships will support the SCP BH CP's overall success. The agencies have well over 300 collective formal and informal linkages within these communities. Among key relationships are alliances with numerous community-based agencies and healthcare systems. Some examples of existing community collaborations include:

- *Advocacy Organizations:* Wareham Homeless Coalition and Wareham Substance Abuse Coalition for SSMH; Cape Organization for Rights of the Disabled for Gosnold; and, Cape Cod Regional Network on Homelessness for FC.
- *Community Behavioral Health Organizations*: Northeast Behavioral Services for SSMH; Martha's Vineyard Community Services for Gosnold; and, Barnstable County Health and Human Services Advisory Council for FC.
- *Community Health Centers, including FQHCs:* Manet Community Health Center, the Greater New Bedford Community Health Center, and Brockton Community Health Center for SSMH; Outer Cape Health Center for Gosnold; and, Duffy Health Center for FC.
- *County/City Organizations:* Barnstable County Human Services for Gosnold; and, Community Network of Cape Cod-Steering Committee for FC.
- *Courts and Justice System:* Plymouth, Wareham and Brockton Courts for SSMH; Federal Probation/Parole for Gosnold; and the Community Outreach Initiative Network for FC.
- *Cultural Organizations:* Quincy Asian Resources, SSMH; and, Wampanoag Tribe, FC.
- *Domestic Violence Intervention Organizations:* South Shore Women's Shelter and DOVE, Inc. for SSMH; and, Independence House for FC.
- *Educational Institutions:* Bridgewater State University, Massasoit Community College, Cambridge College, and Quincy College for SSMH; Cape Cod Community College for Gosnold; and, Barnstable Public Schools for FC.
- *Faith-Based Organizations:* Cape Cod Council of Churches for Gosnold and FC.
- *Hospital Systems:* Brockton Hospital, Steward Health Systems, South Shore Hospital, BID-Plymouth, BID-Milton, Tobey Hospital, Southcoast Health System, McLean Hospital SouthEast, and Arbor Health System for SSMH; Nantucket Hospital, Cape Cod Hospital, Falmouth Hospital, and South Shore Hospital for Gosnold; and, Cape Cod Hospital for FC.
- *Housing and Homelessness Services:* Father Bill's Shelter and Wareham Homeless Coalition for SSMH; Housing Assistance Corporation for Gosnold; and, Housing Assistance Corporation Executive Board for FC.
- *LTSS:* Countryside Adult Day Health for SSMH; Visiting Nurses Association of Cape Cod for Gosnold; and, Vinfen for FC.
- *Medication Assisted Treatment*: Manet Community Health Center for SSMH; and, Habit OpCo for Gosnold and FC.
- *Nutrition Services:* The Falmouth Service Center and Falmouth Food Pantry for Gosnold.
- *Physical Activity:* Korben School of Horsemanship, East Coast Athletics, Fitness Elevation, and Maria Mock for Gosnold.

- *Safe and Healthy Living Environment:* Mental Health First Aid USA Instructor Program for SSMH; and, Recovery Without Walls for Gosnold.
- *Services for Individuals with Developmental Disabilities:* Road to Responsibility, Inc., Amego-Brockton and South Shore Arc for SSMH; and, Hyannis DDS for FC.
- *Specialized Services:* the Massachusetts Rehabilitation Commission (MRC) for SSMH; AIDS Support Group of Cape Cod for Gosnold; and, South Shore PFlagg for FC.
- *SUD Facilities:* Spectrum for SSMH; SSTAR for Gosnold; and, High Point for FC.
- *Vocational Services*: Attleboro Enterprises for SSMH; Job Training and Employment Corporation for Gosnold; and, Cape Abilities for FC.
- *Transition Services:* Father Bill's for SSMH; and, Duffy Health Center for Gosnold.

2. How we will grow connections to the community in the Service Areas.

The BH CP Team will apply our collective affiliations to broaden communities' understanding of BH CP services. The Team will work with community-based agencies and programs, including homeless shelters, to develop an Authorization Form for obtaining client permission to share identifying information with the BH CP Team. In building these information-sharing channels, the Team hopes to assess whether an individual in the care of a community-based organization has been identified by an ACO or MCO as an Assigned Enrollee. Agencies can then contact the BH CP to inquire as to whether an individual in their service is an Enrollee. For Assigned Enrollees, the BH CP Team will then work with the Community Provider to engage the person. Under a variety of state and federal privacy laws, it is likely that the Team will be unable to inquire about Assigned Enrollees; however, if such Enrollees are engaged in a community-based organization, the organization can then obtain the necessary Authorization in order to inform the Team and facilitate engagement. For unassigned cases, the Team can provide education on how the Provider can reach out to EOHHS or the MCO to request Assignment.

3. Plan to ensure staff is informed of resources over the contract term.

Sustaining community relationships requires excellent communication and customer service on a day-to-day basis. The SCP BH CP Team will offer robust orientation to staff as described in Section 7.3 C. In addition to staff orientation related to community connections and communication, the Team will leverage existing technological systems, such as Constant Contact and other organizational marketing resources, to develop and distribute an Electronic Quarterly Newsletter to the Provider community on services and outcomes related to the BH CP. We expect that as the Provider community becomes increasingly aware of the Team, our combined efforts to outreach and engage difficult-to-engage populations will produce optimum outcomes. In addition, SCP BH CP staff will receive a resource binder that serves as a living document. The binder will be reviewed at trainings and staff meetings and updated on a regular basis.

7.3.C Community Partner Supports and Activities

1. Outreach and Active Engagement

a. Planned strategies for outreaching to and engaging with Assigned Enrollees, including individuals who are homeless and hard to reach, within the timeframes specified in the Contract - The SCP BH CP Team will conduct a range of outreach initiatives to engage Assigned Enrollees. SSMH, Gosnold, and FC have deep collective experience and resources across Southeastern Massachusetts for engaging vulnerable and hard-to-reach populations, including individuals affected by serious mental illness, substance use disorders, and complex co-occurring presentations. Such individuals often experience associated socio-economic challenges, which include poverty, impermanent housing and homelessness. SSMH, Gosnold, and FC engage with this population through a variety of existing programs and evidence-based practices, which encompass strategies like assertive engagement, integrated models, crisis services, and creative collaborations with other community organizations. Notable among these creative programs is Gosnold's Community Outreach and Intervention Program, which links Recovery Coaches with 30 Police Departments across Southeastern Massachusetts and Cape Cod in response to non-fatal overdose events. The Community Outreach and Intervention Program leverages the post-overdose event as a pathway to inpatient and continuing treatment.

Leveraging Expertise from Existing Programs and Evidence-Based Practices - SSMH, Gosnold, and FC will continue their work with existing collaborators and forge new partnerships to facilitate access for Assigned Enrollees. The capacity of SSMH, Gosnold, and FC to meet with BH CP clients in accessible, familiar, comfortable and inviting settings is key to effective engagement in the BH CP model. Our approach is rooted in evidence-based practices implemented in our existing program models. For example, Programs of Assertive Community Treatment (SSMH), REACH (SSMH, Gosnold and FC), Children's Behavioral Health Initiative (SSMH, Gosnold, and FC), Community Support Program (SSMH, Gosnold and FC), Here-for-You (SSMH) all use coordinated strategies to engage vulnerable and disconnected populations.

In response to each BH CP Assigned Enrollee, SSMH, Gosnold, and FC have designed the following Outreach and Engagement Protocol:

1. Within five business days of referral, make internal case assignment;
2. Within 10 days and not later than 30 days of referral, engage in progressively intensive Outreach activity to contact the Assigned Enrollee. The SCP BH CP Team will use telephone, visit locations family to the Assigned Enrollee, face-to-face contact, and other electronic means of communication;
3. Every day, conduct a Morning Multi-Disciplinary Team Meeting, similar to the model used in PACT services, to review status of Referrals, Outreach, and Engagement of Assigned Enrollees. The team will also evaluate the success of strategies used to convert Assigned Enrollees to Engaged Enrollees, and to formulate specific outreach and engagement strategies for hard-to-engage enrollees. Using WEBEX and other technological capacities, the SCP BH CP Team will periodically conduct Morning Meeting across multiple Hubs in order to share best practices, strengths, and challenges across the three organizations.

4. Draw from Evidence Based and Emerging Practices currently used by SSMH, Gosnold, and FC in programs such as CBFS, PACT, REACH, and CSP. The agencies will use the following EBPs and EPs during Engagement and Outreach activities:
    a. SBIRT (Screening, Brief Intervention and Referral to Treatment);
    b. Motivational Interviewing; and
    c. Trauma-Informed Assessment and Intervention.
5. Conduct intensive outreach to frequent engagement sites, including EDs, Emergency Services Providers, DMH Site Offices, Homeless Shelters, Residential and/or Respite Programs, Primary Care Practices, Sober Living Residences, etc.
6. Work with community-based agencies and programs, including homeless shelters and other resource agencies, to develop an Authorization Form to gain and document consent for information sharing with the SCP BH CP Team. Community organizations will use this form with their clientele in order to share identifying information from Assigned Enrollees with the Team to promote communication, collaboration, and engagement.
7. Apply the BH CP Team's existing multi-cultural and linguistic competencies to engage diverse populations, including African American, Asian (Mandarin, Cantonese), Cape Verdean, Haitian Creole, Southeast Asian, Spanish, and Portuguese. Affiliated Partner, FC has specialized competency in this area, serving as part of the MBHP Cultural Broker Program. FC has deep community resources, including with organizations such as the Boston Refugee and Immigrant Assistance Center (RIAC), Southeastern Coalition, Bosnian Center, and Ascentria Care Alliance.

Leveraging Community Partnerships- SSMH, Gosnold, and FC will staff BH CP Hub locations with a diverse staff who understand the importance of engaging clients and addressing needs in ways *clients* deem accessible, helpful, and desired. This means providing services to clients in locations outside the traditional office-based mental health treatment center. Instrumental to our engagement efforts is each client's natural supports and other community providers who support client participation in the BH CP program. Working with the client and natural supports, SSMH, Gosnold, and FC will create shared understanding and clear expectations about the scope of BH CP services and provide reference information verbally, as well as in writing, in multiple languages to align with diverse capacities and learning styles. We detail the breadth and depth of these Community Partnerships earlier in Section 7.3 (B).

Leverage Experience with Integrated Models and Crisis Services - SSMH and Gosnold presently offer integrated behavioral health services in physician practices and other settings. As part of the Steward ACO, SSMH offers embedded clinical services in Hawthorne Medical Associates Primary Care Practices in North Dartmouth. SSMH also works with CHART 2 clinicians at Beth Israel Deaconess-Milton, which improves provider-to-provider communication and service access. Finally, SSMH embeds clinicians in Manet Community Health Center, Taunton which further enables close care coordination and integrated treatment between primary and behavioral health services. These relationships with ACOs and primary care practices build linkages to a diverse range of healthcare providers in Southeastern Massachusetts communities.

Similarly, Gosnold embeds clinicians at Harbor Community Health Center, in Hyannis and Plymouth locations, and with Briarpatch in Sandwich and Nantucket. The organization has a history of integrated programs at Falmouth OBGYN, Pleasant Lake Medical, and Brewster.

Gosnold is presently building capacity in its Centerville clinic for co-located medical services offered by Community Health Center of Cape Cod, scheduled to begin in summer 2017.

Leverage Experience as Emergency Service Provider (ESP) - SSMH serves as the ESP in Quincy, working with Emergency Departments in Quincy, Milton, and South Shore Hospitals. Effective May 2017, Gosnold serves as the ESP Provider on Nantucket through a contractual relationship with BMC. Additionally, Gosnold has embedded Recovery Navigator Services at South Shore Hospital, Falmouth Hospital, and Cape Cod Healthcare. Emergency Services Programs assist individuals and families to stabilize emergency mental health conditions and refer to appropriate inpatient or continuing care services. Similarly, Recovery Navigators work within Emergency Departments to coordinate referral to an appropriate level of care for individuals with substance use disorders or co-occurring mental health and substance use disorders. These types of programs specialize in managing care transitions – a competency directly related to operating BH CP services.

Through ESP and Recovery Navigator roles, SSMH and Gosnold have cultivated deep relationships with a variety of behavioral health, addiction recovery, primary care practice, LTSS, and other social support agencies across the Commonwealth. This comprehensive constellation of relationships will serve clients enrolled in the proposed BH CP program. Additionally, existing Crisis Teams and Recovery Navigation services will help to identify when Assigned Enrollees or Engaged Enrollees present in Emergency Departments where SSMH or Gosnold have a presence.

Leverage Staff Training and Technology - SSMH, Gosnold, and FC have comprehensive staff training and professional development capacity within their respective organizations. In an effort to build and sustain strong relationships with community providers, and to ensure share efficient and accurate exchange with community providers, the SCP BH CP Team will provide training on community resources during Orientation.

The SCP BH CP Team also plans to use technological solutions to engage Assigned and Engaged Enrollees. Gosnold's Incident Tracker can be expanded to SSMH and FC. Incident Tracker is a web-based platform that provides automatic reporting pathways, notifying staff when one of their clients has experienced a high risk event, or admission to the hospital. For example, once a staff person enters information about an event like a client hospitalization, the Incident Tracker will notify the Care Manager, Care Coordinator, and RN identified in the client's Treatment Plan. This system will ensure swift intervention in discharge and continuing care planning across the SCP BH CP system.

SCP will implement an electronic Care Management Platform with the capacity to generate reminder emails and texts to clients. With client consent, these reminders will be used to engage Assigned and Engaged Enrollees in communication with the BH CP, initiate contact, remind them of upcoming appointments, and perhaps eventually support them in self-management of their conditions. As part of its CBFS service, SSMH must contact assigned clients within 72 hours of referral. The organization achieves this timeframe by phone outreach, provider outreach, and if needed, outreach to the client's last known address. SSMH will apply these strategies to enhance SPC BH CP operations.

b. Planned strategies for outreaching to and engaging with Assigned Enrollees with Substance Use Disorders - Gosnold brings to the SCP BH CP partnership particular expertise in engaging Assigned Enrollees with Substance Abuse Disorders. Presently, Gosnold Recovery Navigators integrate in communities across Southeastern Massachusetts using four primary strategies. First, Gosnold leads Family Support Groups and these are instrumental to leveraging family strengths to get individuals with SUDs into treatment. Second, Gosnold's Prevention Department regularly engages with schools and communities through a Speakers Program, which includes Recovery Coaches and others with Lived Experience, including Chris Herren, who serves in a Gosnold leadership role. Third, Gosnold embeds Recovery Navigators in South Shore Hospital, Falmouth Hospital, Cape Cod Hospital, and Brockton Hospital (pending). Navigators work with client, family, and community providers to institute a Continuing Care Plan designed to promote lasting recovery. Fourth, Gosnold's Community Outreach and Intervention program links the organization's Recovery Coaches with 30 Police Departments across Southeastern Massachusetts and Cape Cod. After non-fatal overdose events, Coaches and Police reach out to these individuals to facilitate admission into detoxification services, which initiates the recovery process. Nearly 80% of adults who are engaged through the Outreach and Intervention Program enter into treatment. In addition, Gosnold will have a lead role in the SCP BH CP Team related to engaging with community groups such as NAMI, Prevention and Substance Abuse Coalitions, and Housing and Shelter Coalitions, such as the Massachusetts Housing and Shelter Alliance (MAHASA) among others.

c. Planned process to obtain and document Assigned Enrollee's agreement to participate in CP Supports through a participation form. - The Southeast Community Partners, LLC will implement a shared standardized Participation Agreement Form (PAF) to document each client's agreement to participate in the BH CP. Each client will also authorize a Release of Information to providers they permit the BH CP to contact. The SCP will pursue Memoranda of Understanding to facilitate communication and coordination of care with providers who frequently serve Assigned and Engaged Enrollees.

The SCP BH CP Team will ensure that BH CP clients understand that all services are voluntary and how they may opt out of the BH CP or request a new Community Partner. The BH CP Team will educate Enrollees about the key goals and benefits of the BH CP, including:

i. Promotes access to care;
ii. Assists in navigating a complex system of care;
iii. Offers education and support related to managing complex and chronic conditions;
iv. Prioritizes an integrated treatment approach to improve communication and health outcomes; and
v. Helps clients prioritize care and planning needs.

2. Comprehensive Assessment and Person-Centered Treatment Planning

a. Process for conducting Comprehensive Assessments, including how the Bidder will ensure the Assigned Enrollee participates in the assessment process. - Beginning at engagement, a BH CP Care Coordinator will begin the assessment process. The length of the assessment process will determined by the level of engagement between the staff and Enrollee and will not exceed three months. At the first meeting, the Care Coordinator will complete the Enrollee Assessment

Tool and Basic Needs Identification Form. The Care Coordinator will assess whether the client is currently receiving services from any state agencies, such as DMH, DDS, or MRC. The assessment will gauge the Enrollee's ability to communicate symptoms, concerns or care goals, preferred language, employment status, legal status, education, informal supports and any current treatment plans. The form will identify medication, housing, clothing, food, medical conditions, substance abuse, critical risk behaviors, and entitlements. Based on the obtained information, the Care Coordinator will develop a short-term plan to address any identified critical needs. In cases where there is an existing Comprehensive Assessment conducted within three calendar months of the Assigned Enrollee's Assignment, the BH CP will use the existing assessment in lieu of conducting a new assessment. *Please see Attachment 7.3.C.2 for the proposed Enrollee Assessment Tool and Basic Needs Identification Form.*

Enrollee involvement begins at the time of central intake, when each is requested to complete a self-assessment form providing key information about conditions, current providers, treatments, and medications. The form also yields information on the client's ability to communicate concerns, symptoms, and treatment goals. Care Coordinators review the form in the presence of the client and integrate the self-assessment into the care plan, respecting client voice and choice. The assessment continues as the Care Coordinator meets with the client and gathers any additional information needed to provide a comprehensive list of current services and service providers, medical history (clients and families), and medical needs. The assessment will also include the client's medications, prescribers, and pharmacies and the purpose of each to address specific diagnoses or symptoms. The Care Coordinator will seek client consent to obtain relevant information from other providers, and, if not clinically contraindicated, from client family members and other natural supports. The assessment process is a critical part of getting to know the client and building a respectful relationship. For this reason, Care Coordinators will use effective engagement methods such as Motivational Interviewing which helps to meet the client where he or she is at, and identify next steps that the client is ready to undertake. In addition, trauma informed approaches are important for the many clients who have experienced trauma which may be difficult to revisit as the assessment addresses behavioral health history. Cultural competency is critical in building relationships and in accurately understanding information communicated. Wherever possible, the SCP BH CP Team will assign a culturally and linguistically competent Care Coordinator. If needed, the BH CP will supplement staff resources first by an interpreter, and second, by electronic interpreting solutions.

Once the assessment is complete, the Care Coordinator will submit it to the RN and Care Manager for review and approval, communicating results with the care team, ACO, MCO and other providers as necessary.

b. Person-Centered Treatment Plans

1) Planned processes for developing the Person-Centered Treatment Plan, including ensuring the Assigned Enrollee participates in the process - The SCP BH CP Team will address care planning as a collaborative process directed by clients in partnership with providers, other natural supports, other area stakeholders and service providers aimed at meeting behavioral health and medical treatment needs, as well as additional needs dictated by social determinants of health. The information obtained in the comprehensive assessment is the basis for development of a Person-Centered Treatment Plan (PCTP) within 3 months of client assignment.

In order to promote recovery and maximize opportunities for compliance and success, each PCTP will be individualized to reflect the client's need, preferences, priorities, and cultural, religious and other belief systems. Engaged Enrollees will be encouraged to develop his/her PCTP goals and asked to agree with identified goals prior to PCTP implementation. Each Engaged Enrollee's PCTP will include:

- The results of the Comprehensive Assessment and any assessments conducted for social services;
- The types, frequency, and duration of services, and how services and care will be integrated and coordinated among the Assigned Enrollee's health care providers, including but not limited to Recovery Support Navigators and other community and social service providers;
- The Assigned Enrollee's long and short-term goals designed to reduce risk and help manage the complexity of the Assigned Enrollee's health conditions;
- Planned date for reassessment;
- Identification of barriers to meeting goals and consideration of the Assigned Enrollee's ability to adhere to treatment plans;
- A crisis plan; and
- A contact list that includes the Assigned Enrollee's current and preferred method of contact and phone numbers and email addresses of the Assigned Enrollee's PCP, Care Coordinator, care giver (if any) and emergency contact(s).

2) The PCTP will be a comprehensive document that is entered into the care management platform shared by SCP and FC, providing a complete and accurate reference on planned care available to the client's care team on a timely basis. The Person-Centered Treatment Plan will be unique to each Assigned Enrollee, and will reflect his or her preferences, needs, and cultural considerations, as indicated by the Enrollee's signature or other indication of agreement. It will be documented in writing. However, to ensure that the Assigned Enrollee clearly understands the Person-Centered Treatment Plan, it will also be prepared in alternative methods or formats (e.g., audio taping), when needed, or translated into the primary language of the Assigned Enrollee or his/her legally authorized representative, if any, and explained with the assistance of an interpreter. With client consent, the PTCP will be shared with the Assigned Enrollee's PCP or PCP Designee, whose approval will be requested.

3) *Planned processes for updating the Person-Centered Treatment Plan.* - All three organizations are skilled in providing recovery oriented person-centered treatment planning. The BH CP Team will initiate a review process following a change in the Engaged Enrollee's status that is due to progressive disease, functional decline, or resolution of a problem that represents a consistent pattern of change that is not self-limiting; impacts more than one area of the Engaged Enrollee's health status; and requires a review by the BH CP Team. Long- and short-term goals as well as crisis prevention plan will be reviewed on a quarterly basis. The PCTP will be reviewed at least every six months to assess goal progress, health status, monitoring compliance with PCTP, and documenting any updated recommendations or modifications to the PCTP. Such reassessment, monitoring and updating shall include, but not be limited to:

- Determining the Engaged Enrollee's progress toward goals;
- Reassessing the Engaged Enrollee's health status;
- Reassessing the Engaged Enrollee's goals;

- Monitoring the Engaged Enrollee's compliance with the Person-Centered Treatment Plan;
- Documenting recommendations for follow up; and
- Updating the Person-Centered Treatment Plan, as necessary, to reflect the reassessments.

The BH CP Team will seek approval from the Engaged Enrollee on any updates to the PCTP and the Engaged Enrollee's PCP or PCP Designee. The BH CO team will again provide the Engaged Enrollee with a copy of the updated PCTP once approved by the PCP or PCP Designee.

4) Planned process for ensuring the Assigned Enrollee and the Assigned Enrollee's PCP or PCP Designee approve the Person-Centered Treatment Plan. - Upon completion of the PCTP, clients will be asked to sign the plan. Each client will receive a paper copy of the PCTP to use as a working document on the path to recovery. Once signed, the Care Coordinator will solicit the client's permission to share the PCTP with other members of the client's care team. If permission is granted, the Care Coordinator will share the PCTP with the client's PCP, ACO or MCO, and other providers as necessary.

3. Care Coordination and Care Management

a. Identification of stakeholders (e.g., providers, state agencies, and community organizations) involved in an Enrollee's care –SSMH and FC will create a specialized Care Team for each Assigned Enrollee that will be comprised of the Enrollee, their PCP or designee, Clinical Care Manager, Care Coordinator, and their BH clinician. If the Enrollee is using LTSS, a representative of that provider will become part of the Care Team. Care Coordinators will also work with each Enrollee to identify pertinent parties that may make important contributions to the work of the Care Team. Additional team members may include any individual important to the Enrollee, such as family members, friends, formal or informal caregivers, sponsors, advocates, specialists and other case managers or state agency designees. Care Coordinators will also review the Assessment, EHR record for other providers, and - with client consent - seek information from other providers, ACOs/MCOs, and any other individual who may recommend appropriate members of the Care Team. The Care Team will continually consider whether additional members are needed or would contribute to the Team. Engagement of an Enrollee's key provider and natural supports encourages buy-in and is positively correlated with achieving the goals identified in the Care Plan.

b. Information Exchange - The Care Coordinator will provide for the transfer of all appropriate information required for coordinating an Enrollee's needs. Driven by Care Plan goals, the Coordinator will facilitate each Enrollee's sustained health, wellness, and recovery. The Care Coordinator will be responsible for managing communications and ensuring that all members of the Care Team are synchronized in order to promote streamlined service delivery coordination and improved outcomes. Within the SCP BH CP Team, communication will be facilitated through the capacities of the selected Care Management Platform. For parties outside of the BH CP Team, with the appropriate Release of Information in place, the Team will use phone, fax, E-fax, mail, secure email communications, and the MassHIway in accordance with the requirements of the BH CP program to ensure ongoing communication between all team members, the enrollee's providers, and other stakeholders. The Coordinator may also share and disseminate information in person during discharge and Care Team meetings.

c. Management of the Enrollee' Care Team - Care Coordinators will ensure effective team operations by clearly defining the role of each Care Team member and the Care Planning and Implementation process. The Coordinators will ensure that each documented member of the care team is invited to all meetings and understands the goals, purpose and agenda of the meeting. In the beginning, the Coordinators will discuss the purpose of the team and work with each member of the team to identify and assign roles based on their relationship to the client, their training and/or licensure, and the role, function or type of work they have done with the client in the past. The role and purpose of each individual on the team will be very different depending on the needs of the client and the goals that have been identified. No one role or individual is more important than another. This process will ensure that the team functions based upon established and clearly defined processes that are goal oriented, person centered and driven by the client and his/her needs. Each member and role will be documented and available to the entire team.

d. Communications - Effective communication implies that the communication and documentation shared will be informative to the recipient and aid in the advancement of treatment goals. Communication amongst stakeholders is extremely important in promoting a client's goals; but, requires the client signing releases of information. The treatment care planning documents will sit in a shared Care Management Platform accessed by the Care Coordinators from all affiliated partners. The Care Team will hold regularly scheduled meetings and will send notice, invites and agendas to all members of the Care Team in advance of the meetings. All BH CP Team meetings will have the ability for a conference call line to encourage participation by all stakeholders. All Care Plans will be sent to PCPs and other appropriate stakeholders with permission from the client, including the ACO or MCO. All appropriate documents necessary to successful Care Planning and intervention with the client will be shared with all relevant parties in a HIPAA compliant fashion via secure email, fax, e-fax, mail, or hand delivered. All Care Plans, treatment goals and safety plans (where appropriate), referrals, and identified resources beneficial to the client will be available to each client via a client/patient portal on the Care Management Platform used by the BH CP Team for this initiative.

4. Care Transitions

Early information about client crises and admissions to higher levels of care is critical in making it possible for Care Teams to optimally coordinate transitions after transfer or discharge. SCP's operation of and affiliation with areas crisis teams will permit early identification of clients being admitted to higher levels of care. The SCP BH CP's Care Management Platform and/or Gosnold's Incident Tracker will provide automatic notifications directly to members of an Enrollee's SCP Care Team when there is a crisis or admission to a higher level of care. It is also our hope that our ongoing communication with the ACO/MCO will aide in the process of early identification of admission to a higher level of care.

When a client has been admitted to a higher/intensive level of care, the SCP BH CP Team will immediately begin to work with social work, case management or nursing staff (after a release has been signed) at the facility to prepare for the client's discharge either back to the community or to another level of care. The BH CP will initiate this contact within one business day of learning of the admission. It is important that the treating facility be aware of the CP Team and

their engagement with the Enrollee and the BH CP Team's role, which can be achieved by educating and informing higher levels of care once The BH CP Team is in place.

The Care Coordinator will assist in the discharge planning process and attend the discharge meeting, when appropriate, along with any other members of the Care Team including outpatient providers, the Enrollee's PCP or representative, CBFS, or state agency representatives who can contribute to the discharge planning process. The Care Coordinator will meet with the client face-to-face within three business days in order to support, plan and assess client service and support needs. The Care Coordinator will update the treatment plan if needed to better address the concerns and add any area of need that may have developed or changed during the course of treatment. The Coordinator will coordinate any additional clinical or supportive services that are needed including arrangement for transportation and provide updates to the care team and the ACO/MCO and share appropriate documentation and records with new providers where appropriate. The Coordinator will also assist the client in any follow up services including transportation, housing, support, education, and relationship building. Many of these connections to service providers may require a warm hand off and it may also be important to work closely with the client to assist him or her to understand the need for attending and following through with all appointments.

5. Medication Reconciliation

Within three days of discharge from an inpatient behavioral health or medical unit, a SCP BH CP RN will reconcile the Enrollee's medications. The RN will communicate with the client's PCP via phone, secure email, fax, or MassHIway to obtain verification that medication orders by the discharging facility were appropriate for the individual. The SCP BH CP Team will also ensure that medication orders are filled accurately. This process may be done in person by the SCP RN, verified by a VNA or MAP provider who communicates directly with the client and RN, or verified via video conferencing between the RN and the Care Coordinator. The RN will speak directly with the client to assess his/her ability to effectively communicate and demonstrate how to take their medications. If clients have questions about their medications, the RN will remind clients that their local pharmacist is an excellent resource.

Care Coordinators conducting home visits can also support medication compliance by using mobile video conferencing to link the client with the RN. This capacity provides added supervision and support around areas of medication education and compliance. Via videoconferencing the RN will talk to the client to identify any issues of non-compliance or discrepancies in prescribing, especially when the client is served by multiple providers. The RN will ask specific questions and review all the medications in the client's possession. Both the RN and the Coordinators will work to educate clients about the importance and health benefits of medication compliance and the potential risks of not adhering to their medication regimen. When clinically indicated (medication non-compliance, confusion around medication administration, multiple complex medication regimens, or functional limitations), the RN and the CC will work with MAT programs, VNA, and Home Health Agencies to identify supports and trained staff for clients that need assistance with medication administration. The SCP BH CP will get releases to be able to share and communicate all necessary and relevant information including the updated medication order forms amongst the client's PCP, MAT, Home Health Agencies and other prescribers. With all interventions described above, the RN is responsible to provide resources

and supports, consistent with each client's linguistic needs and learning style preferences. All communications and activities by the RN will be documented in the client's chart.

6. Health and Wellness Coaching

a. Health and wellness education, coaching and health promotion programs – SSMH, Gosnold, and FC have longtime experience in supporting individuals with significant behavioral and physical health challenges to set and achieve health and wellness goals. Programs such as PACT (SSMH), CSP (SSMH/Gosnold/FC), DBT (SSMH), Partial Hospitalization (Gosnold), Day Treatment (SSMH), and Recovery Coaching (Gosnold) have strong case management, care coordination, and psycho-educational service components. Further, outpatient models - both Center-based and Outreach - in place at SSMH, Gosnold, and FC - also build strong collaborative linkages to Primary Care Practices and other healthcare providers.

Because of enduring connections to the Southeastern Massachusetts' communities they serve, SSMH, Gosnold, and FC have formal and informal linkages to community resources such as YMCAs, YWCAs, privately-owned gyms, equine therapy, holistic counseling centers with augmentative treatment approaches (such as yoga and mind-body approaches), and nutritional planning. The SCP BH CP Team will regularly encourage Engaged Enrollee's use of Recovery Learning Communities (RLCs), which extend across the Southeastern Massachusetts region in Fall River, New Bedford, Taunton, Brockton, Plymouth, and Hyannis. RLCs provide a comfortable and accessible space for adults to learn more about community-based services and available supports to them. Family Support Groups offered by agencies such as Gosnold, are also helpful resources for individuals who have health needs but require education and assistance navigating the healthcare system.

The SCP BH CP will use a standardized Assessment process and instrumentation (attached to this proposal). The Assessment process is collaborative, wherein the Clinical Care Manager, Care Coordinator, or Registered Nurse works with the client to identify health and wellness needs and goals, and to assess resources of interest to the client. Each Hub will employ at least one Care Coordinator with lived experience as a consumer of mental health or substance abuse services. Peer advocates will be instrumental to helping Engaged Enrollees access desired community resources through direct assistance, referral, and support. Peer staff members are also excellent Navigators to community support groups, including Alcoholics Anonymous, Narcotics Anonymous, and Overeaters Anonymous. The assigned Care Coordinator works with the client to integrate goals, objectives, and interventions into the Person-centered Treatment Plan.

A final key element of the health and wellness component to SCP BH CP services is direct psychoeducation provided by the Registered Nurse or designee. We know the BH CP target population often faces comorbid health challenges, including Cardiovascular Disease, Diabetes, Chronic Obstructive Pulmonary Disease, and Obesity. Staff will be able to use direct face-to-face sessions to provide education, to share technological APPs such as MyFitnessPal, OneDrop, mySugr, Glucose Buddy, and other free solutions. The BH CP Team will also have access to Tele-Health technology to enable greater access to BH CP nursing resources.

b. Methods for ensuring the Engaged Enrollee's goals for the health and wellness programs are recorded and tracked in the Engaged Enrollee's Person-Centered Treatment Plan.- Each

client's PCTP will include his/her own health and wellness goals. As such, these goals will be reviewed on a biannual basis, during the overall plan review process. SCP will purchase a Care Management Platform that will capture Qualifying Activities that occur as part of the BH CP's services and track activities related to goals and objectives, including those for health and wellness. System design will be important, with discrete radio buttons that will help categorize Qualifying Activity into services delivered in accordance with the PCTP.

7. Connection to Community and Social Services

a. Plans to evaluate Engaged Enrollees for social service needs, including proposed screening tool(s) - Beginning at the first meeting following the Central Intake, the Care Coordinator will use the Assessment (attached to this proposal) to compile a list of the client's current community and social services supports, as well as any others used in the past. For many individuals, their critical needs assessment may focus on social supports that are fundamental to their stability. These will be immediately addressed in the short-term plan. As the assessment process progresses, the Care Coordinator will speak with clients about what role these supports have had in their lives and how they feel about the level of engagement and support they offer, and make recommendations related to additional resources, perhaps unknown to the client but of relevance or interest. Identified social service needs, goals, objectives, and interventions will populate the client's PCTP. SCP's Care Management Platform that will capture social service needs detailed on the PCTP, as well as Qualifying Activities engaged to address these needs.

b. Care Coordination - As mentioned in other parts of this proposal, including Staffing, Implementation Timeline, and Quality Management, Care Coordinators will receive orientation and training on social services and supports available to SCP BH CP clients. As the scale and capacity of the BH CP grows, the SCP BH CP will increase the number and diversity of community resources it uses. We will maintain and update a Comprehensive Resource Guide and invite community members as guests to our monthly Leadership and Quality Management Team meetings. These meetings will include a Lunch-and-Learn portion to enable information-sharing with key community partners. Community organizations can learn more about the SCP BH CP and meet its staff personally, and the Team can learn more about particular community resources. Relationship-building with community providers, supports, and resources will be an important part of successfully meeting our clients' needs. Oftentimes, direct connections are instrumental to client engagement with assistive services.

c. Collaboration with ACOs to recommend Flexible Services on behalf of Engaged Enrollees, and following-up on the outcomes of such supports – The SCP BH CP anticipates that our Engaged Enrollees will have needs for Flexible Services. The BH CP target population often has inadequate resources for air conditioners (for individuals with Asthma); mattresses and bedding; and healthcare/hygiene products, such as lice treatments and others. The BH CP Team will use a three step process for collaborating with ACOs to recommend Flexible Services. First, the Team will assess needs for Flexible Services as part of standardized Assessment processes. Second, the Team will develop a Reporting & Communication form to request and justify Flexible Services. It will be reviewed internally before the request is submitted to the ACO. Finally, the SCP BH CP Team will review approvals and non-approvals to better understand ACO criteria for authorization. The SCP BH CP Team will also report these data in our Annual Report or as part of Monthly Communications, as preferred by the ACO.

7.3.C.2 ASSESSMENT TOOL

No changes to the attachments included in the original Participation Plan.

7.3.D Innovative Technologies for Service Delivery

SSMH, Gosnold and FC utilize leading edge technologies to help clinicians deliver services remotely to clients. Technology enhanced for mobility and flexibility has been deployed and improves the client experience and continuity of care. For example, SSMH uses a cloud based communications and collaboration tool (RingCentral) which allows anywhere anytime conference between care worker, client, and care team by phone or video. The clinician can share a computer screen with participants, or pass control to the client to complete a self-assessment, a survey, or required medical forms. Business SMS capability, which is used across various devices such as desk phone, cell phone, and computer, eliminates unsecure text messaging between clients and providers. HD video can also be used for tele-psychiatry sessions when needed. This system and capability will be leveraged across the three agencies.

Providers are equipped with a complete set of mobile computing tools for services outside of the clinics. Virtual desktop technology (Citrix) allows staff to connect securely to the EHR anywhere and anytime. Secure remote connections provide access to the EMR, email, and files. Staff have portable Wi-Fi devices for mobile connectivity into the Care Management Platform. A learning management system is also in use and facilitates targeted on demand or scheduled clinical training with compliance reporting, licensing and management reporting.

An appointment reminder solution (ReminderCall) is currently in use at SSMH. The system links directly into the EHR system, captures client appointment data and transfers it to a 3rd party provider. The appointment reminders are sent via text or phone call allowing for confirmations, cancellations or changes. This assistive technology reduces missed appointments and keeps the clients actively engaged. The same ReminderCall technology can be leveraged to remind clients to take their medications.

SSMH, Gosnold and FC will acquire with DSRIP funding, a Care Management Platform (CMP). In addition, as lead agency SSMH is exploring other low cost innovative technologies to augment care coordination and client adherence to treatment goals. The CMP will also enable the electronic transmission of clinical and care information between provider systems and include numerous other interoperability features. The CMP will provide centralized administrative control, and will accommodate broadcast communication capabilities to the care teams for emergency situations, to specific clients, or across all clients when necessary.

A patient portal will also be available within the CMP tool. SSMH, Gosnold and FC will have care workers accessing a single system for all patient centered services, and will facilitate information collection from patients for their care teams in a timely manner and via a secure path. Utilizing a HIPAA compliant platform, the CMP solution will offer administrative controls to formalize documentation processes and workflows and signoff.

Other Adaptive Technologies: The proliferation of wearable technologies offers clients numerous benefits for better health management. For example, clients presenting symptoms of high blood pressure maybe incentivized to wear heart monitors, or those with diabetes could use blood sugar monitors. Achieving better health goes beyond behavioral health treatment. Growth in the use of these new technologies will help improve clinical outcomes for patients with co-morbidities.

7.3.E Personnel and Staffing

1. Organizational Chart

As described above, the SCP BH CP Team proposes to create five Hubs with a shared staffing model to cover each one within the Southern Region Service Area. Each Hub will be managed by one or more of the partners, who will be responsible for hiring the respective staff.

- Hub 1 will be located in Barnstable, covering Barnstable and Orleans, and staffed by FC.
- Hub 2 will be located in Falmouth, covering Falmouth, Oak Bluffs, and Nantucket, staffed by Gosnold.
- Hub 3 will be located in Plymouth, covering Plymouth and Wareham, staffed by SSMH.
- Hub 4 will be located in North Dartmouth, covering Fall River and New Bedford, staffed by Gosnold.
- Hub 5 will be located in Stoughton, covering Attleboro, Taunton, and Brockton, staffed by Gosnold.

Each Hub will be located at a licensed mental health clinic with its full complement of clinical and administrative staffing and resources to support the BH CP Team. A Medical Director will be assigned to each Hub to provide supervision and consultation. Attachment 7.3 E includes an organizational chart of SCP BH CP personnel, senior managers and other staff assigned to carry out the Contractor Responsibilities as articulated in Attachment A, Model Contract.

2. Staffing Model

Below is the SCP BH CP proposed staffing model based on an assumption of 1,000 Engaged Enrollees for the Southern Region Service Areas as articulated in Attachment D.

				FTE's								
CP Staffing Organization	Hub	Service Area	Number of Clients	Director of Integration	Program Director	Medical Director	RN	LPN	Clinical Care Mgr	Care Coordinator	Recovery Coach	Admin Assistant
FCP	1	Barnstable Nantucket Orleans	200	0.1	0.2	0.02	0.6	0.2	0.4	4	0	
Gosnold	2	Falmouth Oak Bluffs	200	0.1	0.2	0.02	0.6	0.2	0.4	3.5	0.5	
SSMH	3	Plymouth Wareham	200	0.1	0.2	0.02	0.6	0.2	0.4	4	0	
Gosnold	4	New Bedford Fall River	200	0.1	0.2	0.02	0.6	0.2	0.4	3.25	0.75	
Gosnold	5	Brockton Taunton Attleboro	200	0.1	0.2	0.02	0.6	0.2	0.4	3.25	0.75	
	Total	All Svc Areas	1000	0.5	1	0.1	3	1	2	18	2	1

3. Recruitment Plans, and Job Descriptions and Qualifications

The SCP BH CP agencies have successfully recruited qualified staff at all levels of licensure, education, expertise and experience. These agencies' reputation, experience and commitment to student and staff training have been invaluable in the training and retention of staff, especially those who provide mobile services such as care management. The SCP BH CP is committed to

regular review of staff compensation levels relative to current industry trends. The agencies use formal, externally compensation surveys to conduct annual assessments of compensation levels.

Starting in November 2017, each organization will post job vacancies for Care Coordinators, Clinical Care Managers and RNs on several different platforms. The organizations will post on their respective websites, and as well as other recruitment sites, such as Indeed, Monster, Social Services, Idealist, and the National Council for Community Behavioral Healthcare. The SCP BH CP Team will also use social media outlets (i.e., Facebook, Twitter, etc.) and other relevant sources such as the MA Association of Community Health Workers (training program) to attract and recruit personnel.

All the agencies have relationships with and a strong recruitment presence at area colleges and universities, including: Boston College, Boston University, Bridgewater State University, Cape Cod Community College, Eastern Nazarene, Lesley College, Simmons, Smith College, Stonehill College, Tufts University, Wheelock College, Cambridge College, Regis College, Rhode Island College, UMass Boston, and UMass Dartmouth. The CPs will host and attend job fairs and other networking events, and advertise employment opportunities on College and University websites. The agencies also offer internship, externship and practicum opportunities with many of the same colleges and training programs. The organizations also plan to recruit current and former students who have experience with FC, SSMH, and Gosnold. Direct mailings to providers, including nurses, social workers, mental health counselors, rehabilitation counselors, and SUD specialists and advertise in professional publications. In addition to these formal recruitment efforts, the SCP BH CP will use an informal network of contacts to identify potential candidates.

Both agencies will conduct Criminal Offender Records Information checks on all BH CP employees, as well as cross-reference the Inspector General's List of Excluded Individuals and Entities upon hiring and monthly thereafter, notifying EOHHS of any discovered exclusions.

Recruitment timeline:

- November 2017: Start advertising
- December 2017: Review applications, conduct screenings, and schedule interviews
- January – May, 2018: Interview and hire qualified candidates
- January – May, 2018: Conduct orientation and training
- June 1, 2018: New staff will be ready to support members

Please see Attachment 7.3 E-3 for detailed job descriptions.

4. Recruitment from cultural and linguistic communities we intend to serve

The SCP BH CP agencies already will continue to post on culturally and ethnically diverse websites and professional organizations, including: Asian American Civic Association, QARI-Quincy Asian Resource Institute, Workplace Diversity.com, El Mundo-Hispanic newspaper in Boston, Elmundoboston.com, Spanish Cultural Association in Boston, National Association of Asian American Professionals, Sampan.org (newspaper and website published by the Asian American Civic Association), National Association of Puerto Rican Hispanic Social Workers, O Jornal-Portuguese/English newspaper in Fall River and New Bedford, Hispanic American Chamber, MAPS-Alliance of Portuguese speakers, Portuguese American Association of

Falmouth, and Portuguese American Journal. The Team will also conduct community outreach with MRC. Lastly, the SCP BH CP Team will highlight its interest in culturally and linguistically diverse candidates in the job postings at colleges and universities. SSMH currently have staff fluent in Mandarin, Cantonese and Malay. The Team will also offer "sign on" bonuses for specific hard-to-recruit positions.

4. Proposed Training, Orientation Plans and Modules for Staff

The SCP BH CP will develop a joint staff training module for newly hired BH CP program staff. All new will attend the SCP BH CP training and be reimbursed for their time through DSRIP funds. The BH CP will provide Care Coordinators, Clinical Care Managers and RNs training through both Live and Online training methods. All BH CP staff will have full access to and are required to complete courses through the Relias Learning online learning management system. Relias Learning is the leader in online training and personnel training record keeping in mental and behavioral health offering over 700 courses online in addition to SCP's customized courses.

Orientation training will include:

1. Two-part Privacy and HIPAA training (live and online)
    a. HIPAA
    b. Review SCP BH CP policies, depending upon the hiring agency
2. Workplace Safety
    a. Live training orientation with safety booklet
    b. Review SCP BH CP off-site safety procedures
3. Compliance and Quality of Care/SSMH Policies (live and online)
    a. Conflicts of interest
    b. Documentation

First 90 days training will utilize the following resources: a supervisor orientation, live training in conjunction with Relias Learning, SAMHSA integrated materials (print, online and webinars), and documentation of compliance for training completion within Relias. Training will cover:

1. Integration model, values in care delivery, collaboration, program: overview, elements, and goals, care planning, and training requirements
2. Population served including training on: BH, SMI, and SUDs
3. Care Coordinator role. Including; Support/Strengthen linkages, coordinating services, crisis intervention, Navigating BH systems, Outreach & Engagement, NASW Case Mgmt. Standards, other contract requirements
4. RNs will get training in medication reconciliation and working in care planning teams.
5. Program Workflow & Expectations:
    a. Communication/Supervision requirements, Training requirements including attending EOHHS or designate provided training, Rounds/Monthly Team Mtgs.
    b. Documentation
    c. Technology
6. Training Completion on following topics:
    a. Cultural Competency
    b. Accessibility/Accommodations
    c. Individual Living/Recovery Principles
    d. Access to care/systems/BH LTSS
    e. Motivational Interviewing

f. Trauma-Informed Care
g. Health and wellness, including health risk factors of: smoking, inadequate nutrition and exercise, and addressing homelessness
h. Medication Reconciliation
i. Assessment and Treatment Planning, and Person-Centered approach
j. Co-morbid medical issues and impact on population served
k. Social determinants such as stable housing, food, social networks

Ongoing training will be conducted by the Program Managers through:

- Individual supervision
- Monthly team meetings and trainings
- Access to monthly clinical trainings (delivered by SSMH both Live and online), and
- Access to all current training resources like in-house, specialty consultations, safety training, CPR/First Aid, and all Relias Learning courses.

Specific examples include best practices in Integrated Care and Evidenced-Based Practice.

6. Staff Retention Strategy.

The SCP BH CP Team will value highly staff commitment. SSMH sponsors an in-house referral bonus program, as well as sign-on and retention bonuses for specific positions. SSMH is one of a few hundred organizations in the country with an American Psychology Association accredited training program, which allows psychologists the opportunity to serve as clinical supervisors for psychology interns. SSMH also offers a social work internship, providing supervision opportunities for many senior level social work staff. This supervisory role allows participating clinicians to remain in their current fields with a broadened scope of work. SSMH provides for vertical advancement based on skill sets and certifications, and horizontal based opportunities for special projects. Furthermore, SSMH strives to promote from within the organization by posting all positions for a minimum of seven days and interviewing qualified internal staff before filling positions externally. In recognition of our employees' dedication and commitment, SSMH established corporate engagement programs, including the annual service awards and the "celebration of staff." SSMH has also developed a multi-pronged approach to staff communication, which includes weekly Senior Management meetings, monthly Management Meetings, electronic CEO updates, as well as establishing a Diversity Committee and a Safety Committee available to all staff.

7.3.E.1 ORGANIZATIONAL CHART

Please see updated staffing model in BH Attachment A.

7.3.E.3 JOB DESCRIPTIONS

The title of the Vice President of Integrated Care has changed to Director of Integrated Care; the responsibilities are the same. Other job descriptions in the attachments to the original Participation Plan remain unchanged.

7.3.F Implementation Plan and Timeline

Please refer to BH Attachment A.

7.3.G Budget Report and Budget Narrative

Please refer to BH Attachment A.

7.3.H Sustainability

During the initial contract term, the SCP LLC and its Affiliated Partner, FC, will work to demonstrate our ongoing value and cost savings benefit. The LLC BH CP Team will also work to ensure that gaps in care do not occur, especially after high intensive levels of care, such as hospitalizations or emergency department visits. Market economics and quality care will assure the sustainability the LLC BH CP program model. After the contract term, SCP LLC, through its contracted agencies, intends to continue providing care management and coordination services. The LLC will maintain its existing relationships will affiliates and consider adding new affiliates depending upon service demand. In particular, the LLC would add affiliates if there is a greater number of Enrollees by geographic location, specific diagnosis, or existing affiliate capacity.

Care management and care coordination have demonstrated success in improving client satisfaction and engagement in integrative care while reducing total medical expenses for clients with co-morbid physical and behavioral health illnesses. The actuarial company Milliman found that the existence of a comorbid psychiatric illness among individuals with chronic illness resulted in an average cost of **$505 more per month** for healthcare. They summarized: *"If a 10% reduction can be made in the excess healthcare costs of patients with comorbid psychiatric disorders via an effective integrated medical-behavioral healthcare program, $5.4 million of healthcare savings could be achieved for each group of 100,000 insured members...the cost of doing nothing may exceed $300 billion per year in the United States."*[1]

Recognizing these potential cost savings of this magnitude will incentivize ACOs to continue contracting with BH CPs at the end of the five-year contract. Greene et. al. (2008) reviewed the impact of behaviorally based care-management programs addressing both chronic illnesses and comorbid psychiatric disorders on a Medicaid population. They found the program expense in addressing patients with comorbid psychiatric illnesses resulted in healthcare savings in excess of 12 times the program cost.

During the initial contract term, the LLC BH CP Team will maintain and expand existing community and healthcare system collaborations and partnerships. At the end of this term, these relationships will be well-established, thereby forging a pathway for long-term engagements aimed at sustaining care coordination service, even in the absence of the BH CP structure. Following the initial contract period, the LLC BH CP and its Affiliated Partner will continue collaborating around care management and coordination activities, given the shared activities and operational structures that will be increasingly well-established throughout the contract term. The LLC BH CP Team will also continue using the established Enrollee Assessment Tool and Basic Needs Identification Form for engaging future clients around care coordination.

Working through the SCP LLC, SSMH and Gosnold with FC as their partner will also identify strategies for securing and supplementing existing internal resources in order to transition BH CP staff to permanent agency positions and also to seamlessly continue providing care management and coordination services to the target high needs population. Each agency will seek outside philanthropic and major donor funding to continue many of the BH CP care management and coordination activities. Currently, SSMH has two major funds, the Linburn Fund and the

[1] *Melek, 2008*

Shulman Fund, currently worth over $150k. Both agencies also have individual giving programs, public and private grant funding, as well as federal, state, and local operating grants. SSMH's existing and developing ACO relationships will allow for additional cost savings opportunities. Lastly, partnerships with community resources and advocacy organizations, such as NAMI, may create opportunities for legislative appropriations through ongoing advocacy, with groups such as the Association for Behavioral Health.

Following the contract period, shared IT capacity will remain intact, after significantly maturing during the contract period. The LLC BH CP Team will continue to use the Care Management Platform, purchased with initial DSRIP capacity building funding, after the contract period. DSRIP funding will also help to establish a sustainable IT infrastructure to support ongoing BH CP supports and activities. Additionally, SSMH will have a strong working relationship with IT Care Management Platform partner(s) by the end of the contract period. Ongoing use of the Care Management Platform will continue to allow for better outcomes and foster measurement of efficiencies, including identify potential cost savings opportunities.

Lastly, as described above, the initial DSRIP funding will also be invested in developing and implementing robust, comprehensive training programs designed to train and orient new care managers and coordinators to a broad array of topics, including areas such as the rationale and structure of MassHealth reform, philosophy of care management, and the role of care management in attaining strengthened access, outcomes and cost. Training will also include administrative requirements such as data input, reporting, use of IT solutions, care management development and tracking. The LLC BH CP Team will continue to use these training modules after the contract period as a means for instilling in new staff an understanding of the value and role that care management and coordination serves in meeting the care needs of high service needs clients.

7.3.I Quality Management and Performance Monitoring

1. Quality Improvement Program

SSMH and Gosnold have formal processes in place to respond to complaints about quality of care, compliance issues, potential privacy breaches, electronic security concerns, and billing issues. Complaints may be made by filing an incident report or anonymously reporting to a Hotline. Both agencies have processes in place for independent internal audits of any clinical program or process as well as business process, which may involve analysis of data from several sources to create an accurate and actionable view of the issue being investigated. When indicated, these processes produce recommendations and/or Corrective Action Plans. Both agencies also have systemic mechanisms for Security Risk Assessment and Consumer/Patient Satisfaction. These commonalities strengthen the SCP LLC and its operations. Each organization has its own teams and committees to further support this Contract:

- The Quality Assurance Committee (SSMH) focuses on client-specific issues related to incidents, complaints, and human rights. The Committee reviews incident and investigative reports, developing corrective action plans when needed.
- Administrative QM Team/Programmatic QM Teams (Gosnold) oversee QM activities.
- The Risk Management Team (SSMH) focuses on clinical risk, providing staff consultations and recommending treatment plan modifications to reduce risk and improve quality of care.
- The Safety Committee (SSMH and Gosnold), conducts regular Safety Assessments of all sites, reviews findings, and uses data to drive improvements.
- The Human Rights Committee (SSMH) includes consumers, family members, and the public.

The SPC BH CP's QM function will incorporate programmatic, QM, compliance, information technology, and managerial strengths of SSMH, Gosnold, and FC into a planned, systemic Quality Management Plan designed to address the key accountabilities associated with the BH CP Contract. The LQMT is the central structure for BH CP QM activities. Together, using a consensus-building process, the SCP BH CP will develop a standardized recurring agenda to guide monthly LQMT meetings. Minutes and associated reports will flow from the LQMT up to the Management Committee, reporting to SCP's Board of Directors.

The following positions comprise the LQMT:

- Director of Quality Management and Compliance Officer (Elizabeth Folcarelli, Gosnold)
- Medical Director, (Richard Reiner, SSMH)
- Director of Care Coordination (Alberta Anderson, Gosnold)
- Director of Information Technology (Shawn Fernandes, SSMH)
- SCP BH CP Hub Clinical Leadership (SSMH, Gosnold, FC)
- Quality Management Staff (SSMH, Gosnold, FC)
- IT Staff (SSMH, Gosnold, FC)
- Contract Management Staff (SSMH, Gosnold, FC)

The Quality Management Plan will rely on the Care Management Platform purchased by SCP to produce performance data. Performance data will reflect BH CP processes pertaining to Engaged Enrollee, Management/Governance, and Contract Accountabilities.

Engaged Enrollee Accountabilities

i. Monthly, the number of clients with an Outreach Activity within 30 days of Assignment
ii. Monthly, the number of clients who need materials in language other than English
iii. Monthly, the number of clients for whom face-to-face contact attempted
iv. Monthly, the number of clients for whom face-to-face completed/total Assigned clients
v. Monthly, the number of signed participation forms/total population
vi. Monthly, the number of Comprehensive Assessments* completed and not completed within 90 days of Assignment
vii. Monthly, the number of PCTPs* completed and not completed within three months of Assignment
viii. Monthly, among completed PCTPs, the number communicated to Parties who need the PCTP
ix. Monthly, the number of PCTPs updated in accordance with 180-day requirement
x. Monthly, the number of Engaged Enrollees with a Health/Wellness activity in their PCTP who had a Health/Wellness activity

**Assessments and PCTP must have all required signatures to satisfy criteria. The selected Care Management Platform will capture signature requirements in order to identify issues associated with engaging the Enrollee's PCP and other supports, as appropriate.*

Governance/Management Accountabilities

i. Develop and execute a plan to cultivate and sustain relationships with ACOs, MCOs, and State Agencies (e.g., DCF, DMH, DDS, DPH, MRC, and others)
ii. Monthly, review service, operational, and financial performance vis-à-vis Service Dashboard (see Client Accountabilities above), LQMT Minutes, and Financial Reports.

Contract Accountabilities

i. Report "receipt" of Assigned Enrollees within one business day
ii. Identify/involve members of the Engaged Enrollee's Care Team to include the following:
    a. Engaged Enrollee's PCP/Designate
    b. Clinical Care Manager
    c. Care Coordinator
    d. Behavioral Health Clinician, and as appropriate
        i. Family
        ii. Specialists and LTSS Services
        iii. Informal Caregivers
        iv. Advocates; and,
        v. State Agencies
iii. Monthly, identify the following that occurred for Engaged Enrollees who experienced a Transition Event:
    a. Involved in Discharge Planning in cases of hospitalization
    b. Updated Treatment Plan
    c. Coordinated Clinical and Support Services, as indicated
    d. Communicated information to existing/new Provider, as indicated
    e. Updated the ACO/MCO

f. Facilitated a "Warm Handoff" including any direct assistance as needed (e.g., transportation), as indicated.

iv. Monthly, identify the number new PCTPs with the following:
   a. Identified Community, Social, and/or Flexible Services Needs
   b. Identified State Agency Involvement
   c. Identified LTSS Involvement
   d. Identified CBFS Involvement

v. Monthly, among population of Engaged Enrollees with an identified community, social, and/or flexible services need, the number of who had a community, social, and/or flexible services activity.

The SCP BH CP Quality Management Plan also includes mechanisms for policy development to ensure SSMH, Gosnold, and FC follow standardized processes across the five designated Hubs in Falmouth, Hyannis, North Dartmouth, Plymouth, and Stoughton. While each organization assumes Hub leadership at designated sites, together these organizations shall develop and follow standardized protocols, data collection and reporting systems, and performance improvement initiatives. Protocols will prepare the SCP for the following:

- Contract Readiness Review
- BH CP Staffing
- Critical Incident Reporting
- Orientation and Training
- Contract Compliance
- Continuity of Operations; and,
- Protections for Assigned and Engaged Enrollees to include but not limited to the following:
  - Grievance Procedures
  - Culturally and Linguistically Competent Service Provision
  - Client Rights; and,
  - Privacy and Confidentiality

In addition to promoting compliance with Enrollee, Governance, and Contract Accountabilities, the LQMT will be responsible for facilitating completion of the Member Status Report, Quality Measures Report, Other Reports, and at least one specific Quality Improvement Initiative as specified in Attachment A: Model Contract. Since Care Coordination and Management functions are inextricably tied to the success of the BH CP program and contract, it is likely that SSMH, Gosnold, and FC will focus on Care Coordination and Management, as described in Section 2.8(B)(5) of Attachment A: Model Contract, as the SCP BH CP's first Quality Improvement Initiative. Particular *Engaged Enrollee Accountabilities* and *Contract Accountabilities* conveyed earlier in this section will provide good data sources for this Quality Improvement Initiative. SSMH, Gosnold, and FC plan to use the Budget Preparation Period to develop the aforementioned QM protocols and systems. Procuring a Care Management Platform to sufficiently capture and report the metrics described in the SCP BH CP's Quality Management Plan will be a critical first step. The incremental steps are described in Attachment 7.3 F, Implementation Plan and Timeline.

7.3.J Coordination with ACOs and MCOs

1. Communication with potential ACOs and MCOs

The SCP BH CP will build upon existing agency relationships to establish partnerships with ACOs and MCOs. SSMH has existing affiliations with numerous ACOs. SSMH and Gosnold have significant experience with MCOs APM and performance-based contracts. Collectively, the agencies have extensive experience serving the target population throught Southeast region. The BH CP believes ACOs and MCOs seek accountable, collaborative, and responsive partnerships with providers who have proven professionalism and attention to high quality services. SSMH reflects these qualities in its longstanding contractual relationships with all Medicaid MCOs for the provision of a full continuum of BH services in the Quincy services areas. In addition, SSMH's Care Management programs - CSP, Here-for-You, and REACH - serve as great models for the BH CP initiative. Similarly, Gosnold has performance-based contracts with BCBSMA and UBH/Optum's Achievements in Clinical Excellence Program. Gosnold ranks at the highest (Platinum) performance level in the UBH/Optum rating continuum. FC also holds numerous MCO contracts as part of its outpatient services. Through these partnerships, the SCP BH CP Team offers a full continuum of inpatient, emergency services, partial, community-support, PACT, CBFS and other mental health and addiction recovery services. Together, the agencies touch nearly all parts of the Commonwealth's public BH system.

Relative to service innovation, SSMH and Gosnold engage regularly with MCOs on varied pilot projects. In 2005 to 2007, MBHP funded a pilot project with UMass Medical to facilitate integrated care between Manet Community Health Center and SSMH. In addition, Beacon Options engaged with SSMH on a pilot program waiving outpatient authorizations, granting SSMH the capacity to manage outpatient utilization. Beacon Options has a similar relationship with Gosnold. Additionally, Beacon Options is working with Gosnold on a new innovation examining particular clinical (outpatient) outcomes using Polaris instrumentation.

Proven performance with ACOs and managing operations across multiple integrated settings are also important SCP competencies. SSMH has engaged with multiple hospital systems and associated PCPs to provide integrated services and embedded mental health clinicians. In addition, SSMH has strong working relationships with several potential ACOs in the Quincy service areas, and is currently engaged with Steward Health Care Systems primary care practices in Quincy, Dorchester, New Bedford, Fall River, Wareham, and Brockton. In conjunction with Steward's Hawthorn Medical in North Dartmouth, SSMH offers capacity for co-located services in the primary care practice, including screening, diagnostic evaluation, short-term treatment and referral, medication management, and psychopharmacological consultation to the primary care providers. Both SSMH and Gosnold manage service coordination through a contract with Quartet Inc., a software company that provides a communication platform between primary care practices and BH providers. Using Quartet, SSMH provides preferred access, real time communication and coordination between PCPs and SSMH's Quincy and Wareham clinics. Physicians initiate service requests through Quartet, which connect directly with SSMH clinicians, who then respond directly to physician requests at intake and provide treatment and care coordination updates on a regular basis. All clients are administered outcome instruments on admission and at six months that include the Patient Health Questionnaire-9 (PHQ9) for depression screening and the Alcohol Use Disorders Identification Test (AUDIT) for SUD.

Gosnold also has experience working collaboratively in hospital systems by embedding Care Navigators in EDs to assess and respond to continuing care needs of individuals with SUD or co-occurring mental health and SUD. Now in EDs at South Shore, Falmouth, and Cape Cod Hospitals, Gosnold has provided more than 200 consultations and has been able to facilitate continued, community-based structured treatment for 62% of patients. Gosnold has integrated services in multiple Primary Care Practices in Plymouth, Hyannis, and Nantucket. The agency is presently pursuing a new strategic initiative with Cape Cod Health Center to co-locate medical services at Gosnold's Centerville Clinic.

2. Branding and Marketing Plans

The SCP BH CP will engage a hybrid branding and marketing strategy that builds upon the individual characteristics and well-established brand identities of each agency. The SCP's strength draws from its capacity to collaborate and share resources across the Southeast Region, while dedicating knowledgeable and expert resources on a localized Service Area basis. ACOs and MCOs will be able to retain a "local feel" with the SCP, even though the SCP offers region-wide services. Marketing for BH CP services will be integrated into each agency's existing marketing strategies and materials, leveraging existing arrangements, referral sources and communication channels. The SCP itself will not conduct specific branding or marketing.

3. Collaboration with Multiple ACOs and MCOs

SSMH will be joining Steward Health Care System's ACO Referral Circle, building upon the existing partnership. As a BH CP, the collaboration with Steward would facilitate referrals, access, service coordination, and service delivery. SSMH is in final negotiations with Signature Health System to embed staff. SSMH currently has clinicians embedded in SSH's ED, which is included in the BMC ACO, to facilitate assessment, coordination and engagement of presenting patients. SSMH also provides co-located clinical and care management services at Manet clinics. This experience with Manet in attributing Medicaid clients for care management is transferrable to the BH CP. SSMH also intends to contract with Tufts Health Public Plan, which is the ACO for BID health system.

The SCP BH CP Team plans to build upon existing relationships, strengthen existing programs well underway with ACOs and MCOs, and maintain excellent communication and performance. Engagement and collaboration with ACOs and MCOs will be coordinated via the Management Team with input from the Community Advisory Committee. Service coordination is in place with many ACOs through existing clinical and care management relationships with PCPs, hospitals, EDs, and administrators. The SCP BH CP Team will further develop these referral relationships, care coordination and clinical pathways through the evolving community and health system partnerships.

4. Conflict Resolution with MCO or ACO.

Conflict resolution with the ACOs and MCOs will be addressed internally through Management Committee, with input from Consumer Advisory Committee, as appropriate. SCP's Board of Directors will address any such conflicts deemed highly serious. The CEO or his designate will remediate significant issues with ACOs and MCOs.

Community Partner Program Budget Report

South Shore Mental Health Center, Inc.

Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Estimated Enrollees- Start of Period (All Enrollees)		500	1,000	2,000	3,000	4,000	
Estimated Enrollees - End of Period (All Enrollees)		1,000	2,000	3,000	4,000	5,000	
Estimated Enrollees - Monthly Average (excl CBFS enrollees)		771	1,350	2,250	3,150	4,050	
Estimated Enrollees - Monthly Average (CBFS enrollees only)		121	150	250	350	450	
Estimated Program Revenue (excl CBFS enrollees)		$ 971,460	$ 2,916,000	$ 4,860,000	$ 6,804,000	$ 8,748,000	$ 24,299,460
Estimated Program Revenue (CBFS enrollees only)		$ 211,750	$ 450,000	$ 750,000	$ 1,050,000	$ 1,350,000	$ 3,811,750
Total Estimated Program Revenue		**$ 1,183,210**	**$ 3,366,000**	**$ 5,610,000**	**$ 7,854,000**	**$ 10,098,000**	**$ 28,111,210**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -	$ -	$ -	$ -
Revenue for Operations		**$ 1,183,210**	**$ 3,366,000**	**$ 5,610,000**	**$ 7,854,000**	**$ 10,098,000**	**$ 28,111,210**

	Program Expenses		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
1	**Salary**		$ 126,917	$ 825,867	$ 2,288,620	$ 3,806,299	$ 5,191,213	$ 6,649,085	$ 18,888,001
2	**Fringe**		$ 25,383	$ 165,173	$ 457,724	$ 761,260	$ 1,038,243	$ 1,329,817	$ 3,777,600
	Total Personnel Costs		$ 152,300	$ 991,040	$ 2,746,344	$ 4,567,559	$ 6,229,456	$ 7,978,902	$ 22,665,601
3	**Training & Professional Development**		$ -	$ 959	$ 2,611	$ 4,276	$ 5,770	$ 7,321	$ 20,937
4	**Travel**		$ 1,728	$ 39,612	$ 112,111	$ 185,825	$ 256,457	$ 330,170	$ 925,903
5	**Equipment**		$ -	$ 1,750	$ 3,000	$ 6,000	$ 6,000	$ 6,000	$ 22,750
6	**Supplies**		$ 1,000	$ 6,750	$ 22,500	$ 37,500	$ 52,500	$ 67,500	$ 187,750
7	**Contract Services** (consulting, professional)		$ -	$ 11,458	$ 33,000	$ 55,000	$ 77,000	$ 99,000	$ 275,458
8	**Software licensing**		$ -	$ 34,325	$ 84,300	$ 131,400	$ 176,400	$ 221,400	$ 647,825
9	**Telecommunications**		$ 2,523	$ 19,312	$ 53,797	$ 87,881	$ 119,515	$ 152,306	$ 435,334
10	**Occupancy** (rent, utilities, maintenance)		$ 1,438	$ 10,063	$ 17,250	$ 34,500	$ 34,500	$ 34,500	$ 132,251
11	**Other**			$ 73,469	$ 207,286	$ 344,455	$ 479,290	$ 614,903	$ 1,719,403
	Total Direct Costs		$ 158,989	$ 1,188,738	$ 3,282,199	$ 5,454,396	$ 7,436,888	$ 9,512,002	$ 27,033,212
12	**Indirect Cost/Administrative Overhead**	**15.0%**	**$ 23,848**	**$ 178,311**	**$ 492,330**	**$ 818,159**	**$ 1,115,533**	**$ 1,426,800**	$ 4,054,982
	TOTAL EXPENSES		$ 182,837	$ 1,367,049	$ 3,774,529	$ 6,272,555	$ 8,552,421	$ 10,938,802	$ 31,088,194
	Surplus/Shortfall		*$ (182,837)*	*$ (183,839)*	*$ (408,529)*	*$ (662,555)*	*$ (698,421)*	*$ (840,802)*	*$ (2,976,984)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Director of Integration	$ 90,000.00	0.5	7	$ 26,250
Program Director	$ 80,000.00	1	3	$ 20,000
Medical Director	$ 200,000.00	0.1	1	$ 1,667
RN (hired March)	$ 76,000.00	1	3	$ 19,000
RN (hired May)	$ 76,000.00	1	1	$ 6,333
LPN	$ 54,000.00	1	1	$ 4,500
Clinical Care Manager (LICSW/LMHC)	$ 68,000.00	1	2	$ 11,333
Care Coordinator	$ 43,000.00	9	1	$ 32,250
Recovery Coach/Peer Specialist	$ 35,000.00	1	1	$ 2,917
Administrative Assistant	$ 32,000.00	1	1	$ 2,667
				$ -
Total Salary (Program Budget Line 1)		**16.6**		**$ 126,917**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 126,917	20%	$ 25,383
Total Fringe (Program Budget Line 2)			**$ 25,383**

Total Personnel*	**$ 152,300**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

Director of Integration will oversee community partners program, including contracting, program operations, marketing, and finance.

Program Director will assume administrative responsibility for meeting staffing, programmatic, financial, regulatory and contractual requirements.

Medical Director will provide consultation to nurses and treatment team, as well as to PCP.

Registered Nurses will provide medication reconciliation, assessment and treatment planning, PCP coordination and health education.

Licensed Practical Nurses will provide care coordination with medically complex cases, medication reconciliation and coordination with medical providers.

Clinical Care Managers will approve comprehensive assessment, and provide treatment planning and treatment plan review, clinical supervision and oversight of the clinical team.

Care Coordinators will provide outreach, engagement, assessment, treatment planning, recovery navigation, care transitions, crisis planning and health and wellness coaching.

Recovery Coaches/ Peer Specialists will provide care coordination for substance use disorders, including access to support services, and care transitions.

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Total Training and Professional Development (Program Budget Line 3)			

Provide a description of each Training and Professional Development line item included in the table above:

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
Planning, Implementation, and Operations Committee				$ 1,728.00
				$ -
				$ -
				$ -
			Total Mileage	$ 1,728.00

Travel Expense Description	Cost
Total Mileage	$ 1,728.00
Parking and tolls	
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ 1,728.00**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

The Planning, Implementation, and Operations Committee is comprised of the leadership team of the CP, from both Spectrum and SSMH. The Committee includes the Director of Integration (whose compensation is not countedin the CP

Leadership Team line item for Operational Staffing, as it is already included in the program budget, but whose mileage is counted here). The CP Leadership Team meets regularly for coordination between SSMH and Spectrum, and will drive strategy, monitor progress, and ensure clear communication throughout the CP. The committee's meeting location will alternate between Worcester and Quincy, so that each time an average of 3 people (half of the committee) will be commuting there.

Mileage for the Planning, Implementation, and Operation Committee is based on an average of 3 people commuting 100 miles round trip between Quincy and Worcester, twice per month for seven months, at a mileage reimbursement rate of $.48 per mile.

3 people * 100 miles per trip * 2 trips per month * 7 months * $.48 per mile = $2,016.

Row 5 - Equipment

Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost
Total Equipment (Program Budget Line 5)			

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Supplies			$ 1,000.00
Total Supplies (Program Budget Line 6)			

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

By June 1, 2018, a total of 18 staff will be hired. Roughly $1,000 is budgeted to cover all office essentials, i.e. copying/printing paper, legal pads, pens, etc.

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
Total Software Licensing (Program Budget Line 8)			

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Ring Central Subscription	11	28	$ 304
iPhone Plan	50	26	$ 1,305
MiFi Device	35	26	$ 914
Total Telecommunications (Program Budget Line 9)			**$ 2,523**

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

RingCentral is a cloud-based communications and collaboration tool that allows the Clinical Care Managers, Care Coordinators and Recovery Specialists to bring a client and other care team members into conference by phone or video. This is also the primary telecommunications tool for SSMH.

iPhone plans provide staff with full accessibility, allowing them to continue supporting clients even while mobile.

The MiFi subscriptions for the iPads provide internet connectivity for staff at all times, facilitating their ability to have full and secure access to records and resources within clients' homes.

Together, these telecommunications tools provide enhanced mobility and flexibility, improving client experience and continuity of care.

All costs are estimated based on prices in existing contracts. Costs per service plan listed above are on a monthly basis. Number of service plans refer to number of FTE with plans multiplied by number of months these staff hold the plans.

The "# Service Plans" refers to the number of per-staff per-month payments (and the cost per service plan refers to the monthly amount). For example, the .5 FTE Director of Integration will work for seven months during the PBP (November – May), and thus has 3.5 (7 *.5) 'service plans' attached.

	A	B	C	D	E	F
229	**Position**	**FTEs**	**# Months**	**Number of RingCentral Subscription Monthly Payments**	**Number of MiFi Subscriptions & iPhone Plan Monthly Payments**	
230	Director of Integration	0.5	7	3.5	3.5	
231	Program Director	1	3	3	3	
232	Medical Director	0.1	1	0.1	0.1	
233	RN (hired March)	1	3	3	3	
234	RN (hired May)	1	1	1	1	
235	LPN	1	1	1	1	
236	Clinical Care Manager (LICSW/LMHC)	1	2	2	2	
237	Care Coordinator	9	1	9	9	
238	Recovery Coach/Peer Specialist	1	1	1	1	
239	Administrative Assistant*	1	1	1		
240	**Program Budget Staffing Subtotal:**	**16.6**		**24.6**	**23.6**	
241						
242	Project Mgr/ System Administrator	0.5	5	2.5	2.5	
243	Help Desk - Tier 1*	0.5	1	0.5		
244	**Infrastructure Staffing Subtotal:**	**1**		**3**	**2.5**	
245	**Total**	**18**		**28**	**26**	

246 * Administrative Assistant and Help Desk - Tier 1 will have RingCentral subscriptions, but not MiFi subscriptions or iPhone plans.

247

248 **Row 10 - Occupancy**

249	Occupancy Expense	Total SqFt	Cost/SqFT	Cost
250	Rent	600	2.08	$ 1,250
251	Utilities	600	0.21	$ 125
252	Repair and Maintenance	600	0.10	$ 63
253				$ -
254				$ -
255	**Total Occupancy (Program Budget Line 10)**			**$ 1,438**

256

257 ***Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:***

260 The occupancy costs will cover 2 locations, serving as hubs and housing the workspaces for staff when they are in the office.

263 Costs were calculated for one month, as the CP will begin leasing the spaces in May 2018, thus for one month of the PBP. Annual costs per square foot would be 12 times what is shown above, i.e. $25/ sq ft for rent.

266 The amounts for Utilities, and Repair and Maintenance (including Janitorial Services) were calculated as a proportion of rent, using comparable existing programs as a basis for calculation.

Row 11 - Other

Other Direct Expense Description	Cost
	$ -
Total Other (Program Budget Line 11)	**$ -**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)	**15.00%**	**$ 23,848.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

For the CP budgets, we adopted 15% administrative overhead rate, which is the lesser between our actual rate and the maximum allowed rate per CP budget guidance.

Community Partner Infrastructure Budget Report

		South Shore Mental Health Center, Inc.							
	Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**	
	PMPM Infrastructure Rate		$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28		
	Engaged Enrollees		1,000	1,000	2,000	3,000	4,000		
	Estimated Infrastructure Funds		$ 700,000	$ 1,032,600	$ 1,235,760	$ 1,634,400	$ 1,885,440	**$ 6,488,200**	
	At- Risk Withhold Rate			25%	44%	63%	81%		
	Withhold			$ 258,150	$ 543,734	$ 1,029,672	$ 1,527,206	**$ 3,358,763**	
	TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 700,000	$ 774,450	$ 692,026	$ 604,728	$ 358,234	**$ 3,579,437**	
	Infrastructure Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
	Technology								
1	**IT Staffing including Fringe**		$ 25,215	$ 49,711	$ 102,796	$ 142,510	$ 173,726	$ 204,008	**$ 697,966**
2	**Development Adaptation of EHR and/or Care Management System**		$ 90,000	$ 95,000	$ 50,000		$ 25,000	$ -	**$ 260,000**
3	**Technology for Service Delivery**		$ 28,008	$ 43,927	$ 31,738	$ 87,956	$ 94,523	$ 71,407	**$ 357,559**
4	**Other Technology Expenses**		$ -	$ 50,000	$ -	$ -	$ -	$ -	**$ 50,000**
	Total Technology		$ 143,223	$ 238,638	$ 184,534	$ 230,466	$ 293,249	$ 275,415	**$ 1,365,525**
	Workforce Development								
5	**Workforce Development staffing including Fringe**		$ 37,497	$ 19,379	$ 21,684	$ 94,872	$ 110,076	$ 35,774	**$ 319,282**
6	**Recruitment Expenses**		$ 12,569	$ 10,778	$ 8,516	$ 13,353	$ 12,389	$ 12,710	**$ 70,315**
7	**Training Expenses**		$ 1,658	$ 2,819	$ 1,369	$ 3,536	$ 2,544	$ 2,641	**$ 14,567**
8	**Retention Expenses**		$ -	$ 19,886	$ 13,765	$ 20,086	$ 18,530	$ 19,049	**$ 91,316**
	Total Workforce Development		$ 51,724	$ 52,862	$ 45,334	$ 131,847	$ 143,539	$ 70,174	**$ 495,480**
	Business Start Up Costs								
9	**Office Equipment (PBP & BP1 only)**		$ -	$ -					**$ -**
10	**Office Furniture (PBP & BP1 only)**		$ 15,429	$ 103,489					**$ 118,918**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**		$ 182,837	$ 183,839	$ 408,529	$ 662,555			**$ 1,437,760**
	Total Business Start Up Costs		$ 198,266	$ 287,328	$ 408,529	$ 662,555			**$ 1,556,678**
	Operational Infrastructure								
12	**Operation Staffing including Fringe**		$ 15,900	$ 44,600	$ 74,324	$ 74,691	$ 75,062	$ 75,436	**$ 360,013**
13	**Other Operational Expenses**		$ 6,040	$ 9,247	$ 14,000	$ 14,000	$ 14,000	$ 12,998	**$ 70,285**
	Total Operational Infrastructure		$ 21,940	$ 53,847	$ 88,324	$ 88,691	$ 89,062	$ 88,434	**$ 430,298**
14	**Indirect Cost/Administrative Overhead Rate**	15.0%	$ 34,846	$ 67,325	$ 47,729	$ 67,651	$ 78,878	$ 65,103	**$ 361,532**
	TOTAL INVESTMENTS		**$ 450,000**	**$ 700,000**	**$ 774,450**	**$ 1,181,210**	**$ 604,728**	**$ 499,126**	**$ 4,209,513**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Project Mgr/ System Administrator	$ 80,000.00	0.5	5	$ 16,667
Help Desk - Tier 1	$ 55,000.00	0.5	1	$ 2,263
IT Contractor (salary reflects full-time at contract rate of $50/hr); fringe excluded for this position)	$ 100,000.00	0.1	3	$ 2,500
	Total Salary			$ 21,429
	Fringe rate	20.0%	Total Fringe	$ 3,786
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 25,215**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

IT Project Mgr/System Administrator will lead efforts on design, configuration and implementation of the Care Manager solution. They will be responsible for the development of standard operating procedures and implementing workflows. By leading the design and optimization of the system, they will maximize its value to clinical staff in their work to serve our clients.

The Help Desk position will provide Tier 1 technology support to program staff, including for their use of the Care Management Platform, enabling them to maximize the value provided to clients.

The IT Contractor will perform the laptop and iPad builds and iPhone provisioning (MDM enrollment) for program staff, ensuring that they are ready to provide services for our enrollees.

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
CMP Development & Implementation	$ 90,000.00
Total Development and Adaptation of EHR and Care Management System (Infrastructure Budget Line 2)	$ 90,000.00

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

The Care Management Platform will assist in identifying client needs thereby promoting greater engagement. The solution will also enable the electronic transmission of clinical and care information between provider systems and include numerous other interoperability features. Patients can communicate with staff through a patient portal, which will facilitate the patients providing information and documentation to their care team in a timely manner and via a secure path. All of these features will enable staff to provide integrated, client-centric care in a highly effective manner.

Costs were estimated through ongoing discussions with Care Management System vendors. This cost estimate is 50% of the total

Row 3 - Technology for Service Delivery

Description of Expense	Cost
Laptops	$ 12,608
Mobile toolkit (iPad, mobile printer, keyboard and Bluetooth)	$ 15,400

	A	B	C	D	E	F	G
63	**Total Technology for Service Delivery**	**$ 28,008.00**					
64	**(Infrastructure Budget Line 3)**						
65							
66	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
67	***contract and how the costs were determined:***						
68							
69	iPads, mobile printers , and iPad keyboard and Bluetooth setups allow our clinical staff to be 100% mobile for full service						
70	delivery on the go. Laptops will be purchased for supervisory staff (nurses and clinical care managers will have both laptops and						
71	mobile toolkits), as well as office-based staff (Admin Assistant and IT staff who will only receive laptops).						
72							
73	Laptop, including 4 years of hardware coverage ($1553 each) + Microsoft Office license ($76) + Laptop bag ($30 each) = $1,659						
74	each $1,659 * 7.6 = $12,608						
	iPad ($500 each) + Mobile printer ($400 each) + iPad keyboard + bluetooth ($200) = $1,100 each						
	$1,100 * 14 = $15,400						
75	Laptops will be purchased for the below newly hired positions in both the Program Budget and the Infrastructure Budget. For						
76	fractional FTE's, the staff person will be allocated between this program and other program(s), and so the costs of their						
77	technology will be allocated proportionally. Mobile toolkits willl purchased only for clinical staff.						
78							

79	Position	FTEs	Number of Laptops	Number of Mobile Toolkits
80	Director of Integration	0.5	0.5	
81	Program Director	1	1	
82	Medical Director	0.1	0.1	
83	RN	2	2	2
84	LPN	1	1	1
85	Clinical Care Manager (LICSW/LMHC)	1	1	1
86	Care Coordinator	9		9
87	Recovery Coach/Peer Specialist	1		1
88	Administrative Assistant	1	1	
89	**Program Budget Staffing Subtotal:**	**16.6**	**6.6**	**14.0**
90				
91	Project Mgr/ System Administrator	0.5	0.5	

	A	B	C	D	E	F	G
92	Help Desk - Tier 1	0.5	0.5				
93	**Infrastructure Staffing Subtotal:**	**1.0**	**1.0**	**0.0**			
94	**Total**	**17.6**	**7.6**	**14.0**			
95							
96							
97	**Row 4 - Other Technology Expenses**						

98	**Description of Expense**	**Cost**
99		
100		
101		
102		
103		
104		
105	**Total Other Technology Expenses**	
106	**(Infrastructure Budget Line 4)**	

107

108 ***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***
109 ***contract and how the costs were determined:***
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111
112
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120 Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

121

122 **Row 5 - Workforce Development Staffing including Fringe**

123	**Position**	**Annual Salary**	**FTEs**	**# Months**	**Total**
124	Director of Recruiting	$ 80,000.00	0.20	5	$ 6,619

	A	B	C	D	E	F	G
125	Recruiters	$ 57,000.00	0.20	4	$ 3,800		
126	HR Coordinator	$ 36,000.00	0.05	4	$ 600		
127	Payroll Manager	$ 65,000.00	0.04	2	$ 433		
128	Director of Benefits	$ 80,000.00	0.04	2	$ 533		
129	Credentialing - Standard	$ 54,000.00	0.35	3	$ 4,725		
130	Credentialing - Advanced	$ 75,000.00	0.02	3	$ 375		
131	Director of Training	$ 93,000.00	0.25	7	$ 13,563		
132	Training Assistant	$ 36,000.00	0.10	2	$ 600		
133							
134							
135							
136		Total Salary	1.25		$ 31,248		
137		Fringe rate	20.0%	Total Fringe	$ 6,250		
138	**Total Workforce Development Staffing including Fringe**				**$ 37,497**		
139	**(Infrastructure Budget Line 5)**						
140							
141	***For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting***						
142	***the terms of the CP's contract:***						
143							
144	The Director of Recruitment will drive the job posting and advertising functions, including attending job fairs, etc, and will also						
145	take part in the review, screening, and hiring of candidates. The Recruiters and HR Coordinator will perform all functions related						
	to reviewing, screening, and hiring candidates. Together these staff will ensure that our programs are fully staffed with top						
	employees, who will provide excellent care to our clients.						
146	The Payroll Manager will complete all set-up processes required in both internal and external payroll systems. The Director of						
	Benefits will complete all required processes pertaining to new employees' benefits, including health insurance and retirement						
	accounts. The Standard Credentialing staff will communciate with new employees and vendors regarding new employees'						
147	credentialing; gather all relevant documentation and resolve any inconsistencies therein; and enter all information in appropriate						
	systems. The Advanced Credentialing staff will determine privileges as appropriate for incoming employees. Together these staff						
	will ensure that all new hires are smoothly and effectively on-boarded so that they can work to serve our clients without						
148	disruption.						

The Director of Training will research and develop training materials and train newly hired staff. The Training Assistant will perform all logistical work required for trainings, including compilation of training materials, room set-up, and e-learning license registration. Together these staff will ensure that all staff serving our clients are fully trained and ready to provide our clients with high-quality care.

The positions listed do represent allocations of actual resources. Of all positions listed, only training curriculum development (part of the Director of Training's responsibility) will be a centralized function performed by SSMH. Thus, part of the funding for the Director of Training is allocated 100% to SSMH, and part of this position's funding, as well as all of the funding for all remaining positions ,is allocated based on the estimated number of engaged clients among Gosnold, SSMH and FCP (i.e. SSMH and Spectrum will do their own recruitment, hiring, training of staff, etc.)

Row 6 - Recruitment Expenses

Description of Expense	Cost
Advertising	$ 5,100.00
Referral & Signing Bonuses	$ 2,882.00
SORI Checks	$ 882.00
Badges & Payroll System Set-up	$ 3,705.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 12,569.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Advertising entails sponsorships on sites such as Glassdoor and Indeed, use of Open Hire and various recruiting websites, postings at local universities and newspapers, and attendance at job fairs. Costs were estimated based on existing job advertising expenses. We are planning that during the PBP, we will spend $1500 on sponsoring a page at Glassdoor, $1400 for an Indeed sponsorship, $600 for OpenHire, $100 for college/university postings, $750 for advertisements in local papers and print advertisements, $250 for advertising on other websites, and $500 at job fairs. In some cases, one advertisement may be used for positions in multiple programs (for example in different CP contracts). In these cases, the costs listed reflect a proportional allocation of the total estimated cost.

Referral bonuses are bonuses given to current employees who refer successful candidates for hire. Costs were estimated based on typical percentages of new hires who are hired through referrals. Referral bonuses are $250 each; we have estimated that 1/5 of

new hires will be through referrals. Costs were determined based on 17.6 FTE's of new hires during the PBP (all program positions, with the addition of Project Mgr/ System Admin and Help Desk). Signing bonuses are bonuses given to RN's who are hired, and are calculated based on the anticipated number of newly hired RN's. Signing bonuses are for RN's (2 to be hired during the PBP), and are $1000 for each RN.

SORI checks are checks as to whether a job candidate has a record of Sex Offense convictions. Costs are estimated based on the number of employees that will be hired.

Together these expenses will ensure that our program is staffed with highly qualified employees who will provide our clients with excellent care.

The creation of organization badges and payroll system set-up fees (paid to external payroll system vendors) ensure that newly

Row 7 - Training Expenses

Description of Expense	Cost
Supplies (including food) for Orientation	$ 494.00
E-Learning Licenses & Training Supplies	$ 1,164.00
Total Training Expenses (Infrastructure Budget Line 7)	**$ 1,658.00**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Supplies for Orientation include printed materials and food served to new employees during Orientation. E-Learning Licenses allow new employees to access training located on our E-Learning system (an external system containing both internally and externally created training materials). Training supplies include the cost of printed training materials, as well as any other costs required for training. Together these expenditures will allow our new employees to be effectively on-boarded and trained.

Costs are determined based on existing Orientation and Training supply costs.

Row 8 - Retention Expenses

Description of Expense	Cost
Total Retention Expenses (Infrastructure Budget Line 8)	

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Business Start Up Costs - Prep Budget Period

Row 9 - Office Equipment

Description of Expense	Cost

	A	B	C	D	E	F	G
236							
237							
238							
239							
240							
241							
242	**Total Office Equipment**						
243	**(Infrastructure Budget Line 9)**						
244							
245	***Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were***						
246	***determined:***						
247							
248							
249							
250							
251							
252							
253							
254							
255							
256							
257							
258	**Row 10 - Office Furniture**						
259	Description of Expense	Cost					
260	Furniture	$ 15,429.00					
261							
262							
263							
264							
265							
266	**Total Office Furniture**	**$ 15,429.00**					
267	**(Infrastructure Budget Line 10)**						
268							

Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:

Office furniture will be procured to set up office hubs for the inital wave of staff hiring.

Total costs are based on estimated $900 per staff person (desk, chair, file cabinet) x 17.1FTE's of initial hires (new furniture is not being purchased for the Director of Integration). Furniture will be purchased for the below newly hired positions in both the Program Budget and the Infrastructure Budget. For fractional FTE's, the staff person will be allocated between this program and other program(s), and so the costs of their furniture will be allocated proportionally.

Position	FTEs	
Director of Integration		New furniture will not be purchased for the Director of Integration
Program Director	1	
Medical Director	0.1	
RN	2	
LPN	1	
Clinical Care Manager (LICSW/LMHC)	1	
Care Coordinator	9	
Recovery Coach/Peer Specialist	1	
Administrative Assistant	1	
Program Budget Staffing Subtotal:	**16.1**	
Project Mgr/ System Administrator	0.5	
Help Desk - Tier 1	0.5	
Infrastructure Staffing Subtotal:	**1**	
Total	**17**	

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

	A	B	C	D	E	F	G
301	**Position**	**Annual Salary**	**FTEs**	**# Months**	**Total**		
302	Marketing Staff	$ 45,000.00	0.4	2	$ 3,000		
303	Quality Assurance Analyst	$ 60,000.00	0.3	1	$ 1,500		
304	CP Leadership Team	$ 100,000.00	0.15	7	$ 8,750		
305							
306							
307							
308		Total Salary	0.85		$ 13,250.00		
309		Fringe rate	20.0%	Total Fringe	$ 2,650		
310				**Total Program Staffing including Fringe**	**$ 15,900.00**		
311				**(Infrastructure Budget Line 12)**			
312							
313	***For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:***						
314							
315	The Marketing Staff will prepare the marketing materials and strategies that will drive our outreach to attributed clients, to increase their awareness of and engagement with our services.						
316							
317							
318	The Quality Assurance Analyst will review program data and metrics regarding quality of care indicators, measurement and outcomes. This will help to ensure that our clients are receiving excellent services, and engage in continuous improvement measures to drive ever increasing quality of care.						
319							
320	The CP Leadership Team (annual salary listed is an average) will meet regularly for planning purposes and for coordination between SSMH and Spectrum. The CP Leadership Team will drive strategy, monitor progress, and ensure clear communication throughout the CP. The Director of Integration's time is not included here, as this position is included in the program budget.						
321							
322							
323							
324							
325							
326							
327							
328	**Row 13 - Other Operational Expenses**						
329	Description of Expense	Cost					
330	Legal Fees	$ 1,340.00					
331	Marketing & Branding Expenses	$ 4,700.00					

	A	B
332		
333		
334		
335		
336	**Total Other Operational Expenses**	**$ 6,040.00**
337	**(Infrastructure Budget Line 13)**	

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Legal consultation is anticipated to address various contracting issues, whether with ACOs/MCOs and between partners, as well as any other legal consultation needs. No budgeted legal costs will be used to contract with EOHHS.

Marketing and branding expenditures will support the development of the first batch of materials that will be distributed to our attributed clients, to increase their awareness of our program. Costs were estimated as follows:
Brochures: $3,020 for brochures
Food gift card to incentivize Member participation – $5 x 140= $700
Direct mail campaign: $0.49 x 1,000 x 2 = $980

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**15.00%**	**$ 34,847.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were

	A	B	C	D	E	F	G
362	***determined:***						
363							
364	For the CP budgets, we adopted 15% administrative overhead rate, which is the lesser between our actual rate and the maximum						
365	allowed rate per CP budget guidance.						
366							
367							
368							
369							
370							
371							
372							
373							

Community Partner Infrastructure Allocation Worksheet

	South Shore Mental Health Center, Inc.						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 700,000	$ 774,450	$ 692,026	$ 604,728	$ 358,234	$ 3,579,437
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Total Spectrum	$ 9,327	$ 27,948	$ 10,569	$ 29,290	$ 31,476	$ 17,066	$ 125,676
Total SSMH	$ 133,896	$ 210,690	$ 173,965	$ 201,176	$ 261,773	$ 180,605	$ 1,162,105
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ 143,223	$ 238,638	$ 184,534	$ 230,466	$ 293,249	$ 197,671	$ 1,287,781
Workforce Development							
Spectrum	$ 11,903	$ 16,664	$ 14,640	$ 42,728	$ 46,951	$ 16,140	$ 149,026
SSMH	$ 39,821	$ 36,198	$ 30,694	$ 89,119	$ 96,588	$ 34,225	$ 326,645
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ 51,724	$ 52,862	$ 45,334	$ 131,847	$ 143,539	$ 50,365	$ 475,671
Business Start Up Costs							
Spectrum	$ 66,023	$ 95,681	$ 136,041	$ 57,733	$ -	$ -	$ 355,478
SSMH	$ 132,243	$ 191,647	$ 272,488	$ 115,638	$ -	$ -	$ 712,016
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ 198,266	$ 287,328	$ 408,529	$ 173,371	$ -	$ -	$ 1,067,494
Operational Infrastructure							
Spectrum	$ 18,464	$ 34,050	$ 31,865	$ 38,560	$ 42,361	$ 27,156	$ 192,456
SSMH	$ 38,323	$ 87,122	$ 104,188	$ 117,782	$ 125,579	$ 83,042	$ 556,036
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ 56,787	$ 121,172	$ 136,053	$ 156,342	$ 167,940	$ 110,198	$ 748,492
TOTAL INVESTMENTS	$ 450,000	$ 700,000	$ 774,450	$ 692,026	$ 604,728	$ 358,234	$ 3,579,438

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	IT Staffing inlcuding Fringe	Recruit, hire, train Project Mgr/System Administrator to support CP Program	11/01/17	03/31/18	Onboarding of IT PM/System Administrator	Hiring and onboarding complete			Hiring of sufficient IT staff	IT Project Mgr/System Administrator prepared for operations		
Technology	IT Staffing inlcuding Fringe	Set up IT Help desk for Care Management Platform	01/01/18	05/31/18	Hiring of IT staff for Help Desk	Hiring complete			Help desk ready for operations	Help Desk ready for Go-Live		
Technology	Development and Adaptation of E.H.R/Care Management System	Procure, install, and test Care Management Platform. Train key staff on use of Care Management Platform.	07/01/17	03/31/18	Care Management Platform installed and tested. Key staff (including IT Project Mgr and Director of Training) trained on Care Management Platform.	Successful installation			Care Management System passed all readiness testing.	Care Management System ready for operations Go-Live		
Technology	Technology for Service Delivery	Acquire and prepare mobile technology such as laptops, printers, cell phones, for first wave of staff	01/01/18	03/31/18	Technology prepared for testing	Technology ready for testing			Technology ready for field operations	Technology distributed to staff and ready for Go-Live		
Workforce Development	Workforce Development Staffing including Fringe	Recruit initial staffing and develop workforce strategy for CP Program growth	07/01/17	05/31/18	Advertising, job fairs, and networking underway. Hiring of initial staffing for startup.	Hiring of initial program staff complete.			Sufficient program staff deployed in field. All operations staff deployed	Staffing sufficient to meet anticipated program enrollment at onset		
Workforce Development	Workforce Development Staffing including Fringe	Develop standardized orientation and recurring BBHCP modules, based on care model	11/01/17	03/31/18	Standardized curriculum	Curriculum that reflects key elements of care model						
Workforce Development	Recruitment Expenses	Implement recruitment strategy	11/01/17	05/31/18	Advertising, job fairs, and networking underway. Hiring of initial staffing for startup.	Hiring of initial program staff complete.			Sufficient program staff deployed in field. All operations staff deployed	Staffing sufficient to meet anticipated program enrollment at onset		
Workforce Development	Training Expenses	Train all first wave program, IT, and admin staff	02/01/18	05/31/18	Training and orientation program ready	Training and orientation materials prepared			Staff training complete (for first wave of staff)	Documentation of training completed by all first wave staff		
Business Start Up Costs	Office Furniture	Procure office furniture and prepare all program sites to support operations	02/01/18	05/31/18	All program sites will have sufficient furnishings to support staff and operations	All sites have sufficient space, furnishings, to support staff			Office sites will support initial staffing and anticipated program growth	All initial staff deployed at sites		
Operational Infrastructure	Operation Staffing including Fringe	Marketing and branding, outreach to stakeholders	11/01/17	05/31/18	Contracting, marketing and outreach to ACO's, MCO's, LTSS, hospitals, PCP's	Marketing and outreach to stakeholders is launched			Working relationships established with key stakeholders	Documentation of incipient relationships with key stakeholders		

BH Community Partner - Staffing Model

South Shore Mental Health Center, Inc.

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	1000	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	1.5	*Total management oversight of BH CP*
3	Medical Director	0.1	*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs	4	
5	Clinical Care Managers (RN)		*Do not include FTEs listed in line 4*
6	Clinical Care Managers (LPHA)	2	*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders		*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff		*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	19	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)	3	*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists		
12	Administrative Support	1	
13			
14			
	Total FTE	30.6	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1:250	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	2:19	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff: The care coordinators will be supervised by the Clinical Care Managers (LPHA).

Section 7.3 Initial DSRIP Participation Plan

7.3.A Executive Summary

1. Goals, identified challenges related to the care delivery system and behavioral health, and proposed solutions to be effectuated through the CP program

SSMH and Spectrum have extensive history working within the existing BH system and have developed a number of strategies to mitigate the challenges inherent in the current culture and service delivery system. The current system creates care silos without the integration needed to maximize the potential of all clients facing the challenges of behavioral health and co-morbid medical issues. The SSMH-Spectrum BH CP will work to solidify already existing relationships with hospital systems, primary care practices and local FQHC to exchange information through a designated care management platform, use of the Mass Highway and other approaches. Care Coordinators will provide the vital link among the entire care delivery team, ensuring consistent communication among medical providers, thereby enhancing outcomes for Enrollees. Both SSMH and Spectrum have a history of co-location and integration. The BH CP Team will also seek to embed care managers in high volume practices to promote access and client engagement.

The SSMH-Spectrum BH CP will capitalize on its existing outreach programs to engage Assigned Enrollees in the process and objectives of care planning and coordination. Policies and procedures developed during the planning phases will provide a structured approach to engagement that involves the entire BH CP Team. Use of a shared care management platform will assist in identifying client needs thereby promoting greater engagement. In engaging clients, the BH CP will focus on the social determinants of health and on addressing the concrete needs that effect positive outcomes and challenge engagement, and on the ability to access appropriate health solutions will be a major focus. The Mass Highway will serve as a vehicle to transmit and receive essential information from the medical side of the service delivery system promoting increased communication and integration that has been lacking in the current system.

2. Number of Assigned and Engaged Enrollees intended to support under the Contract.

The BH CP will support a minimum of 1,000 clients, with the capacity to increase as necessary, within the Quincy Service Area of the Greater Boston Region who are high risk and high need with chronic medical and BH conditions, including SPMI, SUD, and those with co-occurring disorder. The BH CP will engage in targeted outreach strategies to address historically hard to reach clients and those facing numerous challenges relating to their social determinants of health. The BH CP model allows the opportunity to address the highest need and highest cost individuals through a comprehensive, wraparound approach to care that is individualized and organized in a way that decreases the impact of all arenas including access, poverty, homelessness and behavioral health factors while achieving better health outcomes.

3. Service Areas.

SSMH and Spectrum will operate in the Quincy Service Area within the Boston Region.

4. Plans to operationalize the CP program and time frames associated with implementing such activities.

During the five-month Preparation Budget Period, the BH CP will establish a Governing Body, the Consumer Advisory Board, and the QM Committee, as well as a Management Team. The Governing Body and the Management Team will use the Preparation Period to develop policies

and procedures, on which the CAB and QM Team will provide input. These committees will be essential in developing the program as well as continuing to ensure that the needs of Engaged Enrollees and the quality of the program are held to a high standard. The BH CP will establish a procedure to address all Enrollee grievances, as outlined in Section 2.4 H of the Model Contract. The BH CP will utilize the planning period to develop and execute a strategic plan with regard to workforce development and training. SSMH and Spectrum will address the current shortage of qualified staff through development of an internal training and recruitment program. Prior to operational start, staff will be recruited, hired and trained. BH CP leadership staff will be hired first, in order for them to help develop the program, engage in the hiring and training process and be fully integrated into the BH CP Team. During this period, the Management Team will engage in regular meetings with program managers in order to better understand existing services, such as CBFS, ESP and SA services. The Management Team will also begin community outreach to educate the community on the BH CP program. DSRIP funding will support start up and training of all program staff ensuring a smooth transition and appropriate development of expertise. In addition to recruitment and training, the BH CP will use the Preparation Period to ramp-up and build the IT infrastructure, including setting up mobile devices, implementing both the care management software and the data analytics systems. SSMH will provide comprehensive training as detailed in Section 7.3 E. The BH CP will provide trainings in a didactic format for all initial staff with annual trainings promoting continued staff development. The training modules will be videotaped and added to the Relias Learning System to establish a standardized package.

The BH CP will maintain and expand relationships with all contracting ACOs during the planning period. Conversations have already begun with several ACOs, including Boston Medical Center, Signature Health Systems, and Steward Health Systems, as well as their associated health systems, including South Shore Hospital (SSH), BID- Plymouth, and Brockton Hospital. Further, SSMH and Spectrum will maintain existing and foster new collaborative relationships with community-based organizations and state agencies in the service area. During the budget Preparation Period, a care management platform will be implemented, and the BH CP will establish a continuity of operational plans as well as develop a program evaluation based on data and quality indicators aimed at assessing strengths and weakness of the program, level of series delivered, and overall partner collaboration. During the DSRIP period all required documentation will be finalized and approved, including the assessment tool and treatment plans.

Year 1-5

- The Governing Body will meet regularly, and the CAB and QM Committees will meet quarterly. The CAB and QMC will make recommendations as needed for improvement.
- The BH CP Team will conduct regular trainings for new staff on topics such as engagement, documentation and community resources. In addition, staff will also be asked to participate in periodic trainings conducted by EOHHS or its designee, including trainings that cover various aspects of MassHealth payment reform, including ACOs and/or CPs initiatives.
- SSMH and Spectrum view community relationships and collaborations to be an essential component of the BH CP, and significant efforts will be taken to preserve these throughout.
- The BH CP will engage Enrollees using EBPs and community resources, while maintaining all paperwork as required by EOHHS.
- The BH CP will collect and analyze data to inform care management and coordination. Data will be shared with BH CP staff, which will undertake quality improvement as needed.

7.3.B Supporting Populations and Community Engagement

1. Community Connections

Over the years, SSMH and Spectrum have developed longstanding relationships with community and public agencies in the Quincy area, including strong partnerships with schools, social service providers, hospitals, health centers, and emergency responders, as well as the Quincy Mental Health and Drug Courts. Some of SSMH and Spectrum's community connections include:

Hospital- and health-center based connections:

- SSMH has a close relationship with SSH through our ESP team, and we are in the process of working with SSH to expand this relationship into other service areas.
- SSMH clinicians are working in Steward Medical Center's doctors' offices and in the ED.
- SSMH clinicians are embedded in BID-Milton ED and hospital as part of the Chart 2 grant. Spectrum also works closely with the staff at BID-Milton Hospital to manage appropriate referrals into beds, thereby reducing ED boarding times.
- SSMH has a close relationship with Arbour-Quincy, offering many services in the building where Arbour-Quincy operates a partial hospitalization program and an inpatient unit.
- Spectrum is working with Manet Community Health Center to utilize Manet's prevention counseling services within its walls and to provide methadone treatment when appropriate.
- SSMH and Spectrum are currently working with Fallon Ambulance and are exploring alternative destination transport.
- Spectrum's Project Turnabout currently uses Weymouth Primary Care, Allied Health Clinic, Stetson Dental, Weymouth Oral Surgeon, Family Dental, Family Vision and Eye Health.
- Spectrum also has active referral relationships from SSMC who utilize the various levels of care within the Spectrum System for patients who require addictions treatment services.
- Spectrum has had a long standing history of providing detox and addictions services for clients referred from all SSMH programs, most frequently the ESP team.

Housing connections:

- SSMH and Spectrum both maintain a collaborative relationship with Father Bill's Homeless Shelter, who provides shelter services for the Quincy area. SSMH and Father Bill's attend regular meetings together in which shared clients and resources are discussed, including discussions pertaining to hard to engage or locate clients. The collaborative relationship has enabled SSMH the opportunity and resources to meet with these clients within the shelter setting and engage with them through the outreach attempts. Spectrum refers clients to sober housing within the community and to the Father Bill's when appropriate.
- Through PACT and CBFS, SSMH has strong relationships with local housing authorities, such as the Metropolitan Boston Housing Partnership and the Quincy Housing Authority.

Law Enforcement connections:

- An SSMH clinician is embedded with Quincy Police as part of a jail diversion program.
- SSMH and the Milton and Randolph Police Departments as well as Fallon Ambulance are engaged in work groups aimed at better serving their shared populations.
- SSMH also engages in monthly forums with police around MH facilitated by NAMI.
- Through the ESP program, SSMH has developed positive working relationships with the Quincy District Court clinicians, Drug court staff and the Mental Health court staff.
- Spectrum has a longstanding relationship working with the Massachusetts drug courts, accepting referrals, providing service, and mandating feedback in appropriate cases.

Services to maintain a safe and healthy living environment:

- In 2016, SSMH's certified Mental Health First Aid USA Instructors trained nearly 200 parents, teachers, police department personnel and other community groups.

Physical activity and nutrition programs:

- As described above, Here-for-You provides clients with guidance and support on health and wellness topics related to diabetes, asthma, blood pressure, and body mass index.
- SSMH's CBFS includes a Healthy Mind/Healthy Body program in both its residential and community programs that look at all aspects of a client's life to address issues in many areas.
- SSMH's Discovery Day Treatment program provides participants with opportunities to participate in Expressive Art Therapy, a restorative therapy that immerses clients in creative activities. In 2016, SSMH's client artwork was displayed at the Massachusetts State House.
- SSMH and Spectrum use art therapy to encourage clients to build social connections, practice mindfulness, and express themselves more openly and honestly.
- The Discovery Day Treatment team also organized the 4th Annual Holiday Craft and Bake Sale fundraiser event, providing clients with an opportunity to sell their artwork and baked goods in a community forum and also to raise money for art supplies and a nutrition group.

Transition services from institutional settings:

- The CBFS and PACTs team both work with acute hospital settings, long-term hospitals and jails/prisons to successfully integrate people back into the community.
- SSMH works with Father Bill's to do a planned intake and put in place additional supports.

Collaborative relationships with state agencies:

- As described above, SSMH and Spectrum have longstanding partnerships with state agencies, including DMH, DPH, DCF, DYS, and BSAS.
- In 2010, the MA Rehabilitation Commission awarded the Distinguished Employer Award to SSMH in recognition of our "outstanding commitment of time, organization and business expertise resulting in successful employment opportunities for individuals with disabilities."

2. How we will grow connections to the community in the Service Areas.

SSMH and Spectrum are committed to fostering existing community partnerships as well as establishing new ones in an effort to improve our capacity to fulfill the BH CP contract. Both agencies seek to enhance client outcomes by increasing access to care coordination, while delivering cost-effective and non-duplicative services. The agencies will leverage the integrated system of care to create a coordinated alert system that identifies when an Enrollee is accessing the system at any point providing, an opportunity for immediate access for engagement. In addition to directly working with the client and family, SSMH and Spectrum focus on helping the family to build a network of support systems within the community. Along with social and mental health services, this network may include extended family, schools, health care providers, courts, other service providers, community groups, self-help groups, and religious groups.

3. Plans to ensure staff is informed of resources over the Contract Term.

All CP staff will be trained in all areas of BH and the available resources, ensuring a smooth and efficient referral process between partners for BH CP services and community resources. BH CP staff will receive a resource binder that serves a living document. The binder will be reviewed at trainings and staff meetings. Staff will be required to attend community meetings and trainings to remain informed on available services and supports. These meetings will also provide an opportunity for staff to share lessons learned as well as updates on newly available resources.

7.3.C Community Partner Supports and Activities

1. Outreach and Active Engagement

a. ***Planned strategies for outreaching to and engaging with Assigned Enrollees, including individuals who are homeless and hard to reach, within the timeframes in the Contract –***

Together, SSMH and Spectrum provide a full range of services and modalities that will allow the BH CP to offer a continuum of service options to their Engaged Enrollees and will provide increased opportunities for engaging Assigned Enrollees. SSMH's programs at the QMHC site include Community Support Program, Emergency Service Program, Here-for-You, Community Crisis Stabilization, Community Outpatient Services, Intensive Community Support (DMH Respite), PACT, CBFS, and Peer to Peer Program. Spectrum has inpatient and residential services in Weymouth and will be opening a clinic, which will include MAT also in Weymouth. These programs rely on strong community connections. Through the BH CP, SSMH and Spectrum will foster existing community collaboration to engage Assigned Enrollees and establish shared collaborations aimed at holistically serving SMI and SUD clients, who are often siloed. The BH CP structure will also provide a unique opportunity to engage dually diagnosed Assigned Enrollees and provide them with streamlined comprehensive care.

SSMH and Spectrum will conduct a range of outreach initiatives to engage Assigned Enrollees, including activities aimed at particularly vulnerable and hard to reach populations, such as homeless individuals with SMI and/or SUD. SSMH and Spectrum will work with our existing partners and forge new partnerships to in order to facilitate outreach activities in places where the Enrollee may feel comfortable and/or receive supports or services. These activities could take place in settings such as Father Bill's homeless shelters, community mental health centers, and medical facilities. SSMH will use our relationships with community providers in an effort to facilitate engagement of Assigned Enrollees. Our community partners can provide a "soft-hand off" in order to best facilitate engagement. SSMH staff are largely community-based and "meet the client where they are at," with the goal being to meet the client where they are comfortable outside of the traditional office-based mental health treatment center. In an effort to engage Assigned Enrollees, SSMH and Spectrum will also engage the Enrollee's natural supports and other community providers in a discussion about the BH CP service, including how it will support the Enrollee's recovery process as well as the BH CP's role in conjunction with the larger care team. The BH CP will work to create a shared understanding and clear expectations around the scope of BH CP services and provide this information verbally as well as in writing to Engaged Enrollees in multiple languages to support all learning styles.

SSMH will use our relationships with community providers in an effort to facilitate engagement of Assigned Enrollees. SSMH also hires and trains clinical staff with expertise in community centered engagement and support, which will further support engagement efforts. As described above, SSMH has an ongoing partnership with Father Bill's Shelter, which we will build upon to design an alert system that will allow for access to the client if they cannot be reached by other means. Such a system will enable the BH CP Team to have open lines of communication with shelter staff in order to engage homeless clients that historically can be hard to reach. SSMH will also build on our existing relationship with Manet Community Health Center, where we have embedded clinicians, to engage Assigned Enrollees. Our relationship with Manet includes embedded clinicians, allowing the clinicians to have a place to engage with clients during their

medical appointments and an opportunity to offer support from the BH CP. Medical staff could provide a "soft hand off" in order to facilitate trust and engagement.

SSMH currently has several programs (Here-for-You, PACT, CBFS, and CSP) that have hard to engage clients, and we have developed numerous successful strategies to engage them. SSMH will use our existing Crisis Team to identify and alert Care Managers whenever these client access crisis services, are referred to crisis services, or present at any of the three local EDs. This notification will be triggered by our ability to share information through electronic medical records. Care Managers will have access to electronic solutions for tracking clients. SSMH will work with Chart 2 clinicians at BID-Milton to ensure increased communication and access. Chart 2 clinicians at BID-Milton are embedded in the ED and work with a comprehensive team at the BID-Milton hospital. They work with clients that are regularly seen by the SSMH ESP team, but they also consult with the hospital staff on other behavioral health patients in order to provide support and resources, thereby providing an opportunity to engage clients that may not be involved with the ESP. In addition, SSMH has a clinician embedded in the Quincy Police department in order to facilitate clinical services "on scene" and divert from legal involvement. This clinician also facilitates a quarterly meeting with Quincy Police Department, DMH and SSMH along with other community providers. SSMH's onsite clinician will support efforts to engage Assigned Enrollees. Similarly, Spectrum's relationship with the Quincy Court, including the mental health clinician that is imbedded in the Court and the Court forensic clinicians, will be asked to promote engagement of the BH CP.

The SSMH-Spectrum BH CP Team will also use an electronic reminder system to outreach and engage Assigned Enrollees when possible, sending emails and texting to encourage them to use CP support services. CBFS currently has a 72 hour engagement mandate from referral day. We achieve this timeframe by phone outreach, provider outreach and if needed outreach to their last known address. SSMH will apply a similar approach with BH CP Assigned Enrollees. Overall, the BH CP Team will work to increase communication and access to the entire service delivery system as a means for facilitating outreach and engagement of Assigned Enrollees.

SSMH and Spectrum will also use a range of evidence-based and promising practices to engage Assigned Enrollees, particularly those who are typically hard to reach. The BH CP Team will use Motivational Interviewing (MI), which aims to facilitate and engage intrinsic motivation within the client in order to change behavior. MI is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. The Team will also use a solution-focused interviewing-reality based problem-solving approach to deal with issues as they arise by providing a solution-focused framework. In addition, Spectrum provides certifications in mindfulness training and trauma-informed care training, which sensitizes staff to the needs of high risk populations and enhances their ability to engage clients.

b. Planned strategies for outreaching to and engaging with Assigned Enrollees with SUDs. - For Assigned Enrollees with SUDs, Spectrum will provide access within all levels of care including detox, residential and MAT for Care Coordinators to meet with clients. Similarly to the BH CP outreach and engagement strategies described above, Spectrum will create an alert system to inform Care Coordinators when clients are accessing services. Initial efforts will focus on calls and community visits and work with the area hospitals, homeless shelters, and Fallon

Ambulance, to access clients who are currently being served with their system. In addition, Spectrum's BH CP staff will conduct outreach to clients accessing community-based services and those working with the FQHC as a means to meet clients when they come into the clinic for scheduled appointments. Clients that are referred to BH CP services will likely be in different stages of change. BH CP staff members will be trained on assessing these stages and on how to work with clients in each stage in order to better engage and "meet each client where they are.

c. Planned process to obtain and document Assigned Enrollee's agreement to participate in CP Supports through a participation form. - SSMH and Spectrum will implement a shared standardized agreement form providing documentation on each client's agreement to participate and readiness for participation in BH CP care management and coordination services. The BH CP Team will work to ensure that clients understand all services are voluntary, and that they can opt out or request a new community partner at their choosing.

2. Comprehensive Assessment and Person-Centered Treatment Planning

a. Process for conducting Comprehensive Assessments, including ensuring the Assigned Enrollee participates in the assessment process. - Beginning at engagement, a BH CP staff member will begin the assessment process. At the first meeting, the Care Coordinator will complete the Enrollee Assessment Tools and Basic Needs Identification Form. The Care Coordinator will assess whether the client is currently receiving services from any state agencies, such as DMH, DDS, or MRC. The assessment will gauge the client's ability to communicate symptoms, concerns or care goals, preferred language, employment status, legal status, education, informal supports and any current treatment plans. The form will identify medication, housing, clothing, food, medical conditions, substance abuse, critical risk behaviors, and entitlements. Based on the obtained information, the Care Coordinator will put in place a short-term plan to address any critical needs that are assessed.

Each client will be offered a self-assessment form to fill out during the central intake process in order to better participate in the recovery/assessment process. Care Coordinators will review the form in the presence of the client and integrate the self-assessment into the care plan respecting client voice and choice. The assessment tool will include current services and service providers, medical history (clients and families), and medical needs. It will also include medications, prescribers, and pharmacies as well as knowledge of what medication helps address what diagnosis or symptom. The form will also seek to yield information on the client's ability to communicate concerns, symptoms, and goals. The assessment will occur within three months of enrollment, and then annually thereafter. The Care Coordinator will submit the assessment to the RN and Care Manager for review and approval, communicating results with the care team, ACO, MCO and other providers as necessary. Care Coordinators will use engagement techniques such as MI and trauma-informed care techniques, to engage with each Engaged Enrollees natural supports as well as contact current providers to begin to forge a relationship. *Please see Attachment 7.3 C- 2- for the proposed Enrollee Assessment Tools and Basic Needs Identification Form.*

b. Person-Centered Treatment Plans.

1) Planned processes for developing the Person-Centered Treatment Plan, including ensuring the Assigned Enrollee participates in the process - SSMH and Spectrum view care planning as a

collaborative process directed by clients in partnership with providers, other natural supports, other area stakeholders and service providers aimed at meeting the needs dictated by the social determinants of health. The information obtained in the comprehensive assessment permits the development of a Person-Centered Treatment Plan (PCTP) that the client agrees with and that reflects the client's needs in order to promote recovery and maximize opportunities for compliance and success.

Each care plan will be individualized with regard to client need, client preference, client cultural, religious and other belief systems. Assigned Enrollees will be given the opportunity to develop his/her PCTP goals and asked to agree to identified goals prior to implementation of the PCTP. The plan will be produced in a linguistically appropriate format. In cases where an interpreter is required, staff and electronic interpreting solutions will be made available. The PCTP will be developed within three months of client assignment. In cases where there is an existing Comprehensive Assessment conducted within three calendar months of the Assigned Enrollee's Assignment, SSMH and Spectrum will use the existing assessment in lieu of conducting a new assessment. The PCTP shall include all of the following components:

- The results of the Comprehensive Assessment and any assessments conducted for social services including, as appropriate;
- The types, frequency, and duration of services, and how services and care will be integrated and coordinated among the Assigned Enrollee's health care providers, including but not limited to Recovery Support Navigators and other community and social service providers;
- The Assigned Enrollee's long and short-term goals that seek to reduce risk and help manage the complexity of the Assigned Enrollee's health conditions;
- Specific reassessment dates;
- Identification of barriers to meeting goals and consideration of the Assigned Enrollee's ability to adhere to treatment plans;
- A crisis plan; and
- A contact list that includes the Assigned Enrollee's current and preferred method of contact and phone numbers and email addresses of the Assigned Enrollee's PCP, Care Coordinator, care giver (if any) and emergency contact(s).

2) The PCTP will be a comprehensive document created in conjunction with the client and their care team and entered into the care management platform shared by SSMH and Spectrum, allowing for timely and accurate use of data to the stakeholder and utilization of the data to inform practice. The Person-Centered Treatment Plan will be the following:

- Unique to each Assigned Enrollee:
- In writing;
- Reflect the preferences, needs, and cultural considerations of the Assigned Enrollee;
- Be shared with the Assigned Enrollee's PCP or PCP Designee;
- Be prepared in alternative methods or formats (e.g., audio taping) to ensure that the Assigned Enrollee understands the Person-Centered Treatment Plan;
- Be translated into the primary language of the Assigned Enrollee or his/her legally authorized representative, if any, and explained with the assistance of an interpreter to ensure that the Assigned Enrollee understands the Person-Centered Treatment Plan; and
- Be approved by the Assigned Enrollee's PCP or PCP Designee and the Assigned Enrollee.

3) Planned processes for updating the Person-Centered Treatment Plan. - This PCTP will be reviewed at least every six months to assess goal progress, health status, monitoring compliance with PCTP, and documenting any updated recommendations or modifications to the PCTP. Long- and short-term goals as well as crisis prevention plan will be reviewed on a quarterly basis. SSMH and Spectrum are skilled in providing recovery oriented person-centered treatment planning. The BH CP Team will initiate a review process following a change in the Engaged Enrollee's status that is due to progressive disease, functional decline, or resolution of a problem that represents a consistent pattern of changes that: is not self-limiting; impacts more than one area of the Engaged Enrollee's health status; and requires a review by the BH CP Team. Such reassessment, monitoring and updating shall include, but not be limited to:

- Determining the Engaged Enrollee's progress toward goals;
- Reassessing the Engaged Enrollee's health status;
- Reassessing the Engaged Enrollee's goals;
- Monitoring the Engaged Enrollee's compliance with the Person-Centered Treatment Plan;
- Documenting recommendations for follow up; and
- Updating the Person-Centered Treatment Plan, as necessary, to reflect the reassessments.

The BH CP Team will seek approval from the Engaged Enrollee on any updates to the PCTP and the Engaged Enrollee's PCP or PCP Designee. The BH CP team will again provide the Engaged Enrollee with a copy of the updated PCTP once approved by the PCP or PCP Designee.

4) Planned process for ensuring the Assigned Enrollee and the Assigned Enrollee's PCP or PCP Designee approve the Person-Centered Treatment Plan - Upon completion of the PCTP, clients will be asked to sign the plan. Each client will receive a paper copy of the PCTP to use as a working document on the path to recovery. Once signed, the Care Coordinator will solicit the client's permission to share the PCTP with other members of the client's care team. If permission is granted, the Care Coordinator will share the PCTP with the client's PCP, ACO or MCO, and other providers as necessary.

3. Care Coordination and Care Management

a. Identification of stakeholders (e.g., providers, state agencies, community organizations) involved in an Enrollee's care - During the first meeting and continuing through the assessment process, the BH CP staff will use motivational interviewing to engage the Enrollee and to identify the existing members of his/her care team. The BH CP staff will speak with Engaged Enrollees about different aspects of their life (BH treatment, medical treatment, community supports, social supports, and friends/family) in order to gain a better understanding of the Enrollees' support system and to potentially broaden understanding of the Enrollee's needs among care team members. At times, Enrollees may not think of a support system as part of their care team. Through conversations, the BH CP Team may work to expand an Enrollee's care team members. At a minimum, the team will include the PCP, Care Manager, Care Coordinator, and BH clinician. The team may also include natural support system members, such as family members, informal caregivers, sponsors or friends. It may include specialist clinicians, advocates and other state agencies, case managers or LTSS providers consistent with Enrollee needs.

b. Information Exchange - The Care Coordinator provides the connection and transfers all appropriate information to ensure coordination and attention to the client's needs, thereby

facilitating their recovery process. The Care Coordinator will be the "hub" of communication, ensuring that all members of the care team are on the same page in order to promote streamlined service delivery coordination and improved outcomes. The team will use phone and encrypted email communications, in accordance with team member preferences.

c. Management of the Enrollee' Care Team - The BH CP Care Coordinator will ensure that each documented member of the care team has an assigned role based on their relationship, training and licensure. This process will ensure that the team functions based upon established and clearly defined roles. Each member and role will be documented, and the information will be shared with the entire care team. In order to promote continuity of care and no duplication of services, these roles will be reviewed on a regular basis, and the BH CP staff will periodically check-in with all members of the care team to ensure roles are being followed.

d. Communications - The treatment care planning documents will sit in a shared care management platform accessed by the care managers from both the lead agency and the affiliated partner and meeting all criteria for security of health information. The plans will be sent to PCP and other appropriate stakeholders with the knowledge and permission of the client.

4. Care Transitions

The BH CP Team will work with the Engaged Enrollee during all care transitions, which include any changes in treatment settings. SSMH and Spectrum will ensure that the client and care team understand the role of the BH CP in all level of care transitions and that the team appreciates and understands the importance of team communication throughout the transition process. Before a transition, the care team will collaborate with the enrollee, their PCP, ACO, MCO, CBFS, or any other engaged providers, ensuring their presence at discharge meetings, to develop a transition plan that fits the client's needs. During a change of treatment setting or discharge, the BH CP Care Coordinator will contact the treatment facility to commence the discharge coordination process within one business day of knowing that they were placed. SSMH's access to the areas crisis teams will permit early identification of care transitions. The Care Coordinator will meet with the Enrollee face-to-face within three business days following transition, in order to support, plan and assess service and support needs. The Coordinator will utilize MI to explore what may have happened prior to the inpatient hospitalization and help develop a plan to elicit behavior change that will result in proactive solutions to avoid further hospitalizations, if possible. The Care Coordinator will also seek to ensure a smooth transition for clients who move to a different level of care or type of program by assisting with transportation, appointment reminders, education connections, introducing the client to the new program face-to-face, and sharing client records with the new provider. Additionally, the Care Coordinator will update the treatment plan if needed to better address the concerns and add any area if need that may have developed or changed during the transition, and provide status updates to the care team including the client's ACO or MCO.

5. Medication Reconciliation

At discharge from an inpatient stay, a BH CP RN will provide reconciliation of all medications. The RN will communicate with the PCP, Visiting Nurse Association (if applicable), and discharging facility to ensure that all medication orders are documented and filled accurately. The BH CP RN will provide education on the medications, reason for the medication, dosage,

times, routes, and potential side effects. The RN will ensure that the client understands the information and provide written documentation if needed in the language needed to support the clients learning style and linguistic preferences. The RN will also provide additional support to the client or other BH CP staff, as appropriate, in the event of medication non-compliance or any inconsistencies especially with multiple prescribers. Lastly, the RN will check the Prescription Monitoring Program database to ensure that no potential conflicts exist.

Spectrum and SMMH's BH CP staff will be trained in the basics of medication and medication administration in order to best support this process. SSMH has been a partner with the Medication Administration Program (MAP) through the CBFS program, and as such, our staff fully understands the MAP requirements. The CP RN will work closely with the MAP provider if in a MAP program and will ensure that medication order forms from the client's primary prescriber are shared with the MAP provider and updated appropriately.

6. Health and Wellness Coaching

a. Health and wellness education, coaching and health promotion programs - SSMH and Spectrum have incorporated innovative mind/body approaches in many of their programs. SSMH's activities closely align to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) 8 Dimensions of Wellness (Emotional, Environmental, Financial, Intellectual, Occupational, Physical, Social and Spiritual) model incorporating this philosophy into programing and treatment planning. SSMH's health and wellness services include groups that offer yoga, walking, smoking cessation, mindfulness, and nutrition. SSMH also has a group membership to the YMCA in order to provide a place for clients to engage in physical activity, which is demonstrated to reduce anxiety and provide overall mental health benefits. In addition, SSMH focuses on the social aspects with groups and outings focused on social activities such as a bowling and pool groups as well as a Football Sunday outing. Our Peer-to-Peer program provides a living room model where Engaged Enrollees could come during non-business hours to gain peer support, develop friendships and engage in social activities. Many of our programs also feature an expressive art therapy component that has been proven to be beneficial for many clients where traditional therapy and activities are not the right approach. SSMH and Spectrum also offer a DBT program, an evidence-based practice, to which CP clients could be referred. Spectrum offers a trauma certificate program aimed at integrating trauma-informed care throughout our programs.

SSMH and Spectrum will offer these health and wellness supports to BH CP Engaged Enrollees. BH CP staff will provide health education on a variety of medical conditions, including prevention and management. BH CP staff will also provide coaching on strategies for implementing the health and wellness issues identified on each Engaged Enrollee's PCTP. In addition, BH CP staff will work to foster Enrollee participation in community activities, such as the aforementioned support groups as well as SSMH's expressive art therapy program. Spectrum has incorporated mindfulness in both inpatient and outpatient settings to promote self-care at all levels. Spectrum's inpatient facility in Westborough houses a gym for clients in the residential setting. The BH CP will also utilize existing community resources that serve to work with clients on wellness activities. These will include smoking cessation programs, Overeaters Anonymous, nutritionists and health support groups. The BH CP staff will work with PCPs and other members of the care team to better assess and refer clients based on health and wellness needs.

b. Methods for ensuring the Engaged Enrollee's goals for the health and wellness programs are recorded and tracked in the Engaged Enrollee's Person-Centered Treatment Plan. - Each client's PCTP will include his/her own health and wellness goals. As such, these goals will be reviewed at least every six months, during the overall plan review process. BH CP staff would provide coaching, education and support around the range of health and wellness activities available to the Engaged Enrollee and identified in the individual PCTP. Care Coordinators will lead this effort, in conjunction with the Engaged Enrollee's PCP and the CP RN.

7. Connection to Community and Social Services

a. Plans to evaluate Engaged Enrollees for social service needs, including proposed screening tool(s) - Beginning at the first meeting, the Care Coordinator will use MI to compile a list of the client's current community and social services supports, as well as any others used in the past, using the attached Assessment Tool and Basic Needs Identification Form in 7.3 C-2. Through this goal-oriented style, the Care Coordinator will discuss with the Enrollee the role these supports have had in the Enrollee's life and determine how the Enrollee feels about the supports and their effectiveness. The goal would be to both gather information and to ensure an Enrollee-centered approach to help the Enrollee explore and potentially resolve ambivalence around past supports and how to best move forward. The basic needs assessment will indicate the social supports that the client needs within the first 30 days. This process will address any basic needs, such as housing, medication, medical issues, support groups, and substance abuse services. During the assessment process and in the treatment plan, the Care Coordinator will then document the supports that the Enrollee agrees to engage in or any supports that the Enrollee may wish to consider in the future.

During each quarterly assessment, the Care Coordinator will review the services and assess what changes need to be made, referencing the comprehensive service guide of all available community services and supports. The Care Coordinator will focus on supporting clients to build a natural support network, which may include family, friends and community support groups, such as Alcoholics Anonymous.

b. ***Care Coordination*** – SSMH and Spectrum will continue to foster and enhance community connections throughout the Quincy Service Area, while seeking to grow our connections in order to better serve our clients and ensure that resources are available when and where they are needed. Both agencies will continue to engage and promote community collaboration though established and expanded work groups as described above. The agencies will also seek to build upon existing collaborations with local hospitals, such as increasing the use of ED diversion or alternative destination transport whenever possible. SSMH and Spectrum also have established relationships with all three local hospitals (SSH, BID-Milton and Carney satellite at Quincy ED), which will allows for stronger alliance when our Engaged or Assigned enrollees need or engage in these services. Lastly, for homeless and hard to reach clients, housing is often a missing link. Through SSMH's work with local housing authorities and Father Bill's, SSMH has the unique capacity to put in place additional supports, such as address unmet housing needs.

c. Collaboration with ACOs to recommend Flexible Services on behalf of Engaged Enrollees, and following-up on the outcomes of such supports. - As described elsewhere, SSMH and

Spectrum have and will continue to grow relationships with the ACOs. The BH CP will provide education about supports and, as the program grows, gather BH CP data to report back to the ACO, in an effort to increase their support for the BH CP initiative and as a key member of the Engaged Enrollees care plan teams. The BH CP will ensure active and ongoing communication with all members of the BH CP care team. SSMH and Spectrum both have experience collaborating with ACOs to recommend Flexible Services as well as using data to drive practice, responding to the individual needs of each client, and using and partnering with community resources that respond to social determinants of health.

Outside of the BH CP, SSMH and Spectrum's current collaborations will facilitate a referral stream for Engaged enrollees. Enrollees with comorbid medical issues with no medical or less than optimal medical care can be referred to Manet Community Health Center, Steward PCP offices or other medical practices associated with SSH. These three options encompass many specialties, providing Enrollees with numerous care options located throughout the Quincy Service Area.

SSMH and Spectrum also plan to build on the numerous innovative projects currently under discussion area in order to create a better system of care. SSMH and Spectrum are involved in plans to include more embedded clinicians in a variety of medical settings, more community partnerships with the local police departments and EMS systems. These efforts will foster engagement of Assigned Enrollees and provide increased points of contact with Engaged Enrollees, facilitated by early interventions and diversion from the hospitals or jails. Embedded SSMH or Spectrum clinicians will allow for streamlined communications, rapid referrals, and an integrated overall team approach. These community connections will allow the community partner opportunities to engage with the Enrollee in a variety of forums on a more frequent basis.

7.3.C.2 ASSESSMENT TOOL

No changes to the attachments included in the original Participation Plan.

7.3.D Innovative technologies for service delivery (not to exceed 1 page)

SSMH utilizes leading edge technology to help clinicians deliver services remotely to their clients. This mobility and flexibility improves client experience and continuity of care. A cloud-based communications and collaboration tool called RingCentral allows the Care Managers and Coordinators to bring a client and other care team members into conference by phone or video. The clinician can share a computer screen with participants, or pass control of the screen to the client to complete a self-assessment, a survey, or some other required medical form. The system has business SMS capability as well, and can be used across various devices (e.g. desk phone, cell phone, and computer). HD video can also be used for tele-psychiatry sessions when needed.

Providers are equipped with a complete set of computing tools enabling 100% mobility for delivery of services outside of the clinics. Citrix Virtual desktop technology allows care staff to connect securely into the EHR from anywhere, and at any time. The remote connection provides secure access to email, files, and filters internet traffic. Staff also have Verizon mifi devices for connectivity, eliminating any burden for connectivity on the clients served in their homes. A learning management system is also in use for all care providers and facilitates targeted on demand or scheduled training with compliance reporting for licensing and leadership use.

An appointment reminder solution called ReminderCall is currently in use at SSMH. The system links directly into the EHR system, captures client appointment data and securely transfers it to a 3rd party provider. The appointment reminders are sent via text or phone calls allowing for confirmations, cancellations or appointment changes. This assistive technology reduces missed appointments and keeps the clients engaged. The same ReminderCall technology will be leveraged to remind clients to take their medications.

As described above, SSMH will use DSRIP funding to purchase a care management platform. Working with Spectrum, SSMH is also exploring other low cost innovative technologies to augment care coordination and client adherence to treatment goals. The Care Management solution will be HIPAA compliant and include strong access management and audit controls. The solution will also enable the electronic transmission of clinical and care information between provider systems and include numerous other interoperability features. The solution will provide centralized administrative control and accommodate broadcast communication capabilities to the care teams for emergency situations, to relay to specific clients, or across all clients as needed.

A patient portal will also be available within the care management platform. Care Managers and Coordinators will access this single system for all patient centered services, which will facilitate the patients providing information and documentation to their care team in a timely manner and via a secure path. Utilizing a HIPAA compliant platform, the platform will offer administrative controls to formalize processes and workflows like document review and signoff.

SSMH plans to leverage the proliferation of wearable technologies, which offer clients numerous benefits for better health management. For example, clients presenting symptoms of high blood pressure maybe incentivized to wear heart monitors, or those with diabetes could use blood sugar monitors. Achieving better health goes beyond behavioral health treatment. Growth in the use of these new technologies will help improve clinical outcomes for patients with co-morbidities.

7.3.E Personnel and staffing

1. Organizational Chart

Attachment 7.3.E includes an organizational chart of SSMH and Spectrum personnel, senior managers and other staff that will be assigned to the BH CP to carry out the full Contractor Responsibilities as articulated in Attachment A, Model Contract.

2. Staffing Model

Below is the BH CP's proposed staffing model based on an assumption of 1,000 Engaged Enrollees in a 12-month period for the Quincy Service Area as articulated in Attachment D.

Staffing Category	Staff title	**Engaged Enrollees** (1,000 total)	Number of FTEs
Supervision	Medical Director		0.1
	Program Director		1
	Director of Integration		.5
Administration	Administrative Assistant		1
Care Management	Clinical Care Manager (LICSW)		2
	Clinical Care Manager (RN)		3
Care Coordination	Care Coordinators	53	19
	Recovery Coach/ Peer Specialist		3
	LPN		1

Staffing model notes:

- SSMH and Spectrum will both staff Care Coordinators, Clinical Care Managers, and RNs who specialize in either mental health (SSMH) or substance use (Spectrum).
- SSMH and Spectrum will hire a one FTE Program Director.
- The Program Director will determine at intake which clients will be assigned to an RN versus a LICSW Clinical Care Manager based on presenting issues.
- SSMH's Medical Director, Dr. Richard Reiner, and Spectrum's Vice President of Clinical Development, Romas Buivydas, Ph.D., LMHC, will provide leadership, oversight, and supervision to the BH CP Team. Dr. Reiner maintains relationships with medical providers and other resources, including medical directors at local outpatient, diversionary, and inpatient services programs, hospital emergency department physicians, and primary care clinicians. Dr. Buivydas provides training and consultation in co-occurring disorders to program staff and is available for consultation as needed.

3. Recruitment Plans, Job Descriptions and Qualifications

Starting in November 2017, SSMH and Spectrum will post job vacancies for Care Coordinators, Clinical Care Managers and RNs on several different platforms. SSMH and Spectrum will share recruitment strategies and common recruitment channels. Each agency will also have unique sources that they engage separately. SSMH and Spectrum will post on their internal websites, general job websites like indeed.com, and on other BH specific job websites including but not limited to: Masspsych.org, Psychiatry-mps.org, thenationalcouncil.org, careersofsubstance.org, SocialService.com, the new social worker online, NASWMA.org (National Association of Social Workers-MA chapter), and MACHW.org (Massachusetts Association of Community Health Workers). SSMH will also post positions in local newspapers like the Boston Globe, the Boston Herald, Quincy Sun, and Brockton Enterprise and at the South Coastal Career Center in Brockton. SSMH has relationships with and a strong recruitment presence at area colleges and

universities including: Boston College, Boston University, Bridgewater State University, UMass Boston, Simmons, Tufts University, Stonehill College, Eastern Nazarene, Smith College, Wheelock College, Cape Cod Community College, Lesley College, Cambridge College, Rhode Island College, Regis College, and UMass Dartmouth. SSMH plans on attending job fairs and networking events, posting jobs on these school's websites, and directly contacting school's Career Services and head of Social Work and or Psychology programs. Spectrum senior staff serve as adjunct faculty at colleges and universities including Boston College School of Social Work and Assumption College and will actively recruit students through these affiliations.

SSMH and Spectrum are committed to regular review of staff compensation levels relative to current industry trends. Both agencies use formal, externally compensation surveys to conduct annual assessments of compensation levels. SSMH has highlighted plans to continue this approach in the current Strategic Plan under the heading of employee engagement.

SSMH and Spectrum each have a robust internship program that provides opportunities for recruitment. SSMH also offers externship and practicum opportunities with a number of colleges and Training programs, including Cambridge College, Smith College, Simmons, Boston College, and Lincoln Technical Institute. SSMH plans to recruit current and former students who already have experience with the organization. SSMH will also send direct mailings to clinical professionals including nurses, social workers, mental health counselors, rehabilitation counselors, and substance abuse specialists and advertise in professional publications. SSMH also plans to put a profile page on Glassdoor, and add photos, videos and awards. Having a profile page blocks competitors from accessing SSMH's site. SSMH will illicit employees that have a positive view of SSMH to write reviews. We also plan to advertise on Pandora Radio which is more expensive than typical radio shows, but provides an opportunity to target our audience by age, sex and geography. In addition to these extensive formal recruitment efforts, the BH CP will use its informal network of contacts to identify and locate potential candidates.

Both agencies will conduct Criminal Offender Records Information checks on all employees assigned to the BH CP contract, as well as cross-reference the Inspector General's List of Excluded Individuals and Entities upon initial hiring as well as on a monthly basis thereafter, notifying EOHHS of any discovered exclusions.

Recruitment timeline:

- November 2017: Start advertising
- December 2017: Review applications, conduct screenings, and schedule interviews
- January – May, 2018: Interview and hire qualified candidates
- January – May, 2018: Conduct orientation and training
- June 1, 2018: New staff will be ready to support members

Please see Attachment 7.3 E-3 for detailed job descriptions.

4. Recruitment from the Cultural and Linguistic Communities We Intend to Serve

SSMH and Spectrum will continue to post positions on culturally and ethnically diverse websites and professional organizations including: Asian American Civic Association, QARI-Quincy Asian Resource Institute, Workplace Diversity.com, El Mundo-Hispanic newspaper in

Boston, Spanish Cultural Association in Boston, Hispanic American Chamber, National Association of Puerto Rican Hispanic Social Workers, MAPS-Alliance of Portuguese speakers, Portuguese American Association of Falmouth, and Portuguese American Journal. SSMH will also conduct community outreach with Quincy Asian Resources, Inc., the Quincy Career Center (which includes an Asian Access Project), and the Massachusetts Rehabilitation Commission. Lastly, SSMH and Spectrum will highlight their interest in culturally and linguistically diverse candidates in the job postings at colleges and universities. Spectrum also attends job fairs at all area colleges with the aim of recruiting skilled and diverse workforce. Spectrum also uses social media to reach a varied and extensive target audience. Internal promotion of employee referrals through a bonus system assists in recruiting diverse applicant pools.

4. Proposed Training, Orientation Plans and Modules for Staff

SSMH will develop a joint staff training module for newly hired BH CP program staff. Spectrum staff will attend the SSMH training and be reimbursed for their time through DSRIP funds. The BH CP will provide Care Coordinators, Clinical Care Managers and RNs training through both Live and Online training methods. All BH CP staff have full access to and are required to complete courses through the Relias Learning online learning management system. Relias Learning is the leader in online training and personnel training record keeping in mental and behavioral health offering over 700 courses online in addition to BH CP customized courses.

Orientation training will include:

1. Two-part Privacy and HIPAA training (live and online)
    a. HIPAA
    b. Review SSMH or Spectrum policies, depending upon the hiring agency
2. Workplace Safety
    a. Live training orientation with safety booklet
    b. Review SSMH off-site safety procedures
3. Compliance and Quality of Care/SSMH Policies (live and online)
    a. Conflicts of interest
    b. Documentation

First 90 days training will utilize the following resources: a supervisor orientation, live training in conjunction with Relias Learning, SAMHSA integrated materials (print, online and webinars), and documentation of compliance for training completion within Relias. Training will cover:

1. Integration model, values in care delivery, collaboration, program: overview, elements, and goals, care planning, and training requirements
2. Population served including training on: BH, SMI, and SUDs
3. Care Coordinator role. Including; Support/Strengthen linkages, coordinating services, crisis intervention, Navigating BH systems, Outreach & Engagement, NASW Case Mgmt. Standards, other contract requirements
4. RNs will get training in medication reconciliation and working in care planning teams.
5. Program Workflow & Expectations:
    a. Communication/Supervision requirements, Training requirements including attending EOHHS or designate provided training, Rounds/Monthly Team Mtgs.
    b. Documentation
    c. Technology

6. Training Completion on following topics:
    a. Cultural Competency
    b. Accessibility/Accommodations
    c. Individual Living/Recovery Principles
    d. Access to care/systems/BH LTSS
    e. Motivational Interviewing
    f. Trauma-Informed Care
    g. Health and wellness, including health risk factors of: smoking, inadequate nutrition and exercise, and addressing homelessness
    h. Medication Reconciliation
    i. Assessment and Treatment Planning, and Person-Centered approach
    j. Co-morbid medical issues and impact on population served
    k. Social determinants such as stable housing, food, social networks

Ongoing training will be conducted by the Program Managers through:

- Individual supervision
- Monthly team meetings and trainings
- Access to monthly clinical trainings (delivered by SSMH both Live and online), and
- Access to all current training resources like in-house, specialty consultations, safety training, CPR/First Aid, and all Relias Learning courses.

Specific examples include best practices in Integrated Care and Evidenced-Based Practice.

6. Staff Retention Strategy.

SSMH and Spectrum highly value staff commitment and offer incentives and opportunities for growth within the organization. SSMH sponsors an in-house referral bonus program, as well as sign-on and retention bonuses for specific positions. SSMH is one of a few hundred organizations in the country with an APA accredited psychology training program, which allows psychologists the opportunity to serve as clinical supervisors for psychology interns. SSMH and Spectrum also offer a social work internship, providing supervision opportunities for many senior level social work staff. This supervisory role allows participating clinicians to remain in their current fields with a broadened scope of work. SSMH provides for vertical advancement based on skill sets and certifications, and horizontal based opportunities for special projects. Furthermore, SSMH strives to promote from within the organization by posting all positions for a minimum of seven days and interviewing qualified internal staff before filling positions externally. In recognition of our employees' dedication and commitment, SSMH established corporate engagement programs, including the annual service awards and the "celebration of staff." Spectrum also emphasizes annual staff recognition with a birthday care and a gift card for every employee. Spectrum staff members receive benefits reviews regularly, tuition remission opportunities, and access to an online educational system to get continuing education credits. SSMH has also developed a multi-pronged approach to staff communication, which includes weekly Senior Management meetings, monthly Management Meetings, electronic CEO updates, as well as establishing a Diversity Committee and a Safety Committee available to all staff.

7.3.E.1 ORGANIZATIONAL CHART

Please see updated staffing model in BH Attachment A.

7.3.E.3 JOB DESCRIPTIONS

The title of the Vice President of Integrated Care has changed to Director of Integrated Care; the responsibilities are the same. Other job descriptions in the attachments to the original Participation Plan remain unchanged.

7.3.F Implementation Plan and Timeline

Please refer to BH Attachment A.

7.3.G Budget Report and Budget Narrative

Please refer to BH Attachment A.

7.3.H Sustainability

The SSMH-Spectrum BH CP will work to demonstrate our ongoing value and cost savings benefit. The BH CP Team will also work to ensure that gaps in care do not occur, especially after high intensive levels of care, such as hospitalizations or emergency department visits. Market economics and quality care will assure the sustainability the SSMH-Spectrum program model.

Care management and care coordination have demonstrated success in improving client satisfaction and engagement in integrative care while reducing total medical expenses for clients with co-morbid physical and behavioral health illnesses. The actuarial company Milliman found that the existence of a comorbid psychiatric illness among individuals with chronic illness resulted in an average cost of **$505 more per month** for healthcare. They summarized: *"If a 10% reduction can be made in the excess healthcare costs of patients with comorbid psychiatric disorders via an effective integrated medical-behavioral healthcare program, $5.4 million of healthcare savings could be achieved for each group of 100,000 insured members...the cost of doing nothing may exceed $300 billion per year in the United States."*[1]

Recognizing these potential cost savings of this magnitude will incentivize ACOs to continue contracting with BH CPs at the end of the five-year contract. Greene et. al. (2008) reviewed the impact of behaviorally based care-management programs addressing both chronic illnesses and comorbid psychiatric disorders on a Medicaid population. They found the program expense in addressing patients with comorbid psychiatric illnesses resulted in healthcare savings in excess of 12 times the program cost.

During the initial contract term, the BH CP will maintain and expand existing community and healthcare system collaborations and partnerships. At the end of this term, these relationships will be well-established, thereby forging a pathway for long-term engagements aimed at sustaining care coordination service, even in the absence of the BH CP structure. Following the initial contract period, SSMH and Spectrum will continue collaborating around care management and coordination activities, given the shared activities and operational structures that will be increasingly well-established throughout the contract term. SSMH and Spectrum will also continue using the established Enrollee Assessment Tool and Basic Needs Identification Form for engaging future clients around care coordination.

SSMH and Spectrum will also identify strategies for securing and supplementing existing internal resources in order to transition BH CP staff to permanent agency positions and also to seamlessly continue providing care management and coordination services to the target high needs population. Each agency will seek outside philanthropic and major donor funding to continue many of the BH CP care management and coordination activities. Currently, SSMH has two major funds, the Linburn Fund and the Shulman Fund, currently worth over $150k. Both agencies also have individual giving programs, public and private grant funding, as well as federal, state, and local operating grants. SSMH's existing and developing ACO relationships will allow for additional cost savings opportunities. Lastly, partnerships with community resources and advocacy organizations, such as NAMI, may create opportunities for legislative

[1] *Melek, 2008*

appropriations through ongoing advocacy, with groups such as the Association for Behavioral Health.

Following the contract period, shared IT capacity will remain intact, after significantly maturing during the contract period. SSMH and Spectrum will continue to use the care management platform, purchased with initial DSRIP capacity building funding, after the contract period. DSRIP funding will also help to establish a sustainable IT infrastructure to support ongoing BH CP supports and activities. Additionally, SSMH will have a strong working relationship with IT care management platform partner(s) by the end of the contract period. Ongoing use of the care management platform will continue to allow for better outcomes and foster measurement of efficiencies, including identify potential cost savings opportunities.

Lastly, as described above, the initial DSRIP funding will also be invested in developing and implementing robust, comprehensive training programs designed to train and orient new care managers and coordinators to a broad array of topics, including areas such as the rationale and structure of MassHealth reform, philosophy of care management, and the role of care management in attaining strengthened access, outcomes and cost. Training will also include administrative requirements such as data input, reporting, use of IT solutions, care management development and tracking. SSMH will continue to use these training modules after the contract period as a means for instilling in new staff an understanding of the value and role that care management and coordination serves in meeting the care needs of high service needs clients.

7.3.I Quality Management and Performance Monitoring

1. Quality Improvement Program

SSMH's continuous QI process is at the core of the organization's sustained delivery of efficient and effective services. SSMH's Director of Compliance and Quality, Dean Tsapatsaris, LICSW, manages and monitors a variety of QM initiatives, including: quality assurance, QI, and UM. The Director oversees the Meaningful Use Manager and Senior Compliance and Quality Analyst, who work together to monitor QM initiatives. The Director serves as a consultant to any SSMH program wanting to plan a QI project. This consultation includes analyzing data, creating formatted reports, and assisting the program to interpret and utilize the results in an ongoing quality improvement effort. The Director also chairs several SSMH-wide teams/committees.

SSMH's Quality Management Program is based on the following general principles:

- Quality service concerns every clinician and is a major focus of senior management staff. In addition to assuring quality through the retrospective review process, SSMH employs proactive quality management efforts to identify and address issues as they arise.
- Regular involvement in Quality Assurance and Multi-Disciplinary Group activities allows SSMH staff to easily integrate quality standards and include self-monitoring in their own clinical activities, in addition to maintaining compliance with established requirements.
- Managers and clinical staff are available for quality management and review as needed.
- Regular data gathering facilitates changes to organizational functioning and structure by effectively linking quality assurance activities, management, and operational staff.

SSMH's Here-for-You QM plan offers a detailed example of our QM approach. It includes:

- A continuous quality improvement process including outcome measures and satisfaction surveys to measure and improve the quality of care and services delivered to members.
- Outcomes measures used by all partners to identify opportunities for program improvement.
- A technical assistance process provided by Beacon and facilitated by the Quality Analyst that includes quality and process measures shared at regular intervals, thereby enabling the establishment of joint opportunities for improvement when applicable.

SSMH must meet two metrics to be eligible to share in Total Medical Expense savings.

2. Quality Initiative

SSMH and Spectrum will maintain a QI plan established to improve processes and outcomes by using continuous QI principles. The plan will include at least one specific QI initiative to be implemented and evaluated annually. In Budget Period 1, SSMH will focus on the Care Coordination and Care Management Initiative. In order to measure success of this initiative, SSMH will audit and analyze the following measures: 1) medical history identifiable in the record; 2) collateral communication evidence; and, 3) the number of in-person client contacts.

3. Quality Committee

The QM Department is comprised of the Director of Compliance and Quality, the Meaningful Use Manager, and the Senior Compliance and Quality Analyst. QM staff members meet with SSMH managers and line staff on a regular basis to provide consultation and offer trainings on related topics. The Department is responsible for ensuring adherence to the numerous QM requirements stipulated in SSMH's contracts with MBHP and state agencies. In addition, the

Department is responsible for managing and monitoring a variety of internal QM initiatives, including:

- *Quality Assurance Committee:* The Quality Assurance Committee (QAC) is an SSMH-wide committee that serves several roles. QAC meets on a regular basis and has several members, including the Medical Director, Director of Nursing, Director of Quality Management, Human Rights Officers, and representatives from SSMH's Outpatient and the Crisis/Rehab Divisions. The QAC reviews the CQD's incident and investigative reports, developing corrective action plans when needed. When necessary, QAC will recommend that policies or procedures be changed, or certain corrective actions be taken, so that SSMH will continue to meet the highest standards of care. QAC investigates client complaints that cannot be resolved at the program level. QAC approves privileges for clinical staff who meet established criteria to allow those staff to provide specific clinical functions in their work at SSMH. QAC is also responsible for approving the forms and documentation standards for medical records, as well as for reviewing and approving of any research requests.
- *Client Satisfaction:* SSMH has a long history of having consumers and family members participate in quality monitoring. All SSMH programs conduct annual consumer satisfaction surveys. This process provides rich data, as each year we receive approximately 1500 responses across the organization. Although each program has its own individualized questionnaire addressing issues specific to that program, there are six core questions that appear on every program's satisfaction survey. In addition to answering the predefined questions on the survey, we encourage clients to tell us in their own words what is most useful and least helpful about the services they receive from us. When the survey period is complete, the QM team produces reports that show individual program results, compare the results of the six core questions to national benchmarks, and determine if internal standards were met. A report is also provided to all directors analyzing cross-agency program satisfaction. Programs not meeting the standards are required to develop an action plan indicating how they will achieve compliance by the next satisfaction survey period. SSMH has used previous survey results to generate program changes in site locations, develop a centralized intake process, and foster significant growth in home-based outreach services.
- *Clinical Outcomes:* SSMH has long believed that in order assess treatment impact, it is necessary to evaluate outcomes. SSMH uses a variety of standardized tools to measure outcomes. Many of these tools are used to report on Meaningful Use Clinical Quality Measures (MU), Physician Quality Reporting System Quality Measures (PQRS), and Merit-based Incentive Payment System Quality Measures (MIPS). Positive quality outcomes depend on the ability to capture and report on outcomes data. SSMH's outcomes data has guided our team approach to educate staff in the use of these tools, monitor administration compliance, and interpret and use research data.
- *Utilization Management:* As described above, the QM Director uses data to monitor utilization parameters, such as no-show rates and service utilization, and produces monthly reports on access and multidisciplinary team record reviews. SSMH's employs a Quality Analyst to supports this work. The Staff member's functions include describing practice patterns and mining the collected data to help program managers decrease service bottlenecks and improve program effectiveness and efficiency.
- *Staff Performance:* SSMH conducts routine staff evaluations aimed to help each employee and supervisor assess in a constructive way the employee's performance over a specific period of time. Staff evaluations assess employee performance according to clearly identified

and agreed upon standards and objectives in order to assure that goals are being fulfilled. Supervisors monitor clinical performance by reviewing staff notes, case assessments, service plans and outcomes and by discussing cases with staff during supervision. Assessment of staff performance includes utilization, productivity, prior authorization management, case management skills and other non-clinical matters. All employees participate in an annual, formal review process where they receive feedback from supervisors on overall performance.

- *Program Performance:* Program evaluation concentrates on wide-ranging factors, including needs assessment, process evaluation, program efficiency and effectiveness, impact, and outcome evaluation. On a routine basis, QM staff members prepare reports that describe a variety of operational and financial measures on a program by program basis. Program managers review these reports and implement changes needed to meet client expectations.
- *Plan Review Teams:* Plan Review Teams consist of a multi-disciplinary group of senior clinicians that provide quality assurance and clinical risk management on a program/service level. The Teams conduct regular clinical record reviews focusing on appropriateness/quality of treatment provided, insure timely and thorough documentation of all clinical and collateral services provided, and provide data regarding each of the areas to the QM Director. Multi-disciplinary groups complete the initial plan review after developing an initial treatment plan which must be submitted for review after two sessions or 30 days. For clients receiving pharmacotherapy services, treatment plans shall reflect specific target problems expressed in behavioral terms, as well as behavioral goals and timelines for these services. Initial treatment plans are reviewed for quality and completeness. Subsequent reviews are done at least semi-annually, and at other times if required by the regulatory agencies or payers.
- *Human Rights Committee:* The purpose of the Human Rights Committee is to promote, safeguard, and protect the dignity, legal rights and liberties of all SSMH clients. The Human Rights Committee monitors clients' human and civil rights to ensure compliance with State and Federal regulations, ensure compliance with the appropriate human rights standards of accrediting agencies, and make recommendations to improve understanding and enforcement of client rights. The Chief Human Rights Officer staffs the Human Rights Committee, which is comprised of consumers, family members, and members of the public. All Committee members participate in carrying out the duties of the Committee as defined by the Human Rights Committee bylaws. The Committee holds regular meetings at least four times a year, with dates scheduled in June for the following year. In addition, the Committee meets in Special Session as often as necessary upon request. The Committee functions in an advisory capacity to the QM Director.
- *Risk Management Team:* The Risk Management Team supports all SSMH programs in mitigating clinical and operational risk, as well as ensuring staff and client safety, with program staff present presenting cases of high-risk clients. The Team meets on a regular basis and has several members, including the Medical Director, Director of Compliance and Quality, and representatives from the SSMH's Outpatient and the Crisis/Rehab Divisions. The Team also provides consultations to staff and when appropriate makes recommendations for changing treatment plans to mitigate risk and improve quality of care.
- *Safety Committee:* The Safety Committee, co-chaired by the Director of Compliance and Quality and the Vice President of Human Resources, conducts an annual Safety Assessment of all SSMH sites, then makes recommendations for changes and monitors implementation.

7.3.J Coordination with ACOs and MCOs

1. Communication with potential ACOs and MCOs

SSMH has repeatedly demonstrated our skills, expertise and values through longstanding contractual relationships with all Medicaid MCOs for the provision of a full continuum of BH services in the Quincy services areas. SSMH provides care coordination and management through the following Community Support Program: Here-for-You, Children's Behavioral Health Initiative, CBFS, PACT and the REACH program. SSMH has participated in a number of innovative pilot projects with MCOs. In 2005 to 2007, MBHP funded a pilot project with UMass Medical to facilitate integrated care between Manet Community Health Center and SSMH. In addition, Beacon engaged with SSMH on a pilot program waiving outpatient authorizations, granting SSMH the capacity to manage outpatient utilization. DPH and BSAS engaged with SSMH on building capacity for adolescents with co-occurring disorders. In outpatient reviews with MBHP, SSMH demonstrated low ED and inpatient utilization, below 25th percentile.

SSMH has engaged with multiple hospital systems and its primary care practices in providing integrated services. This experience demonstrates the expertise, skill, value and readiness that SSMH offers in working with ACOs as a community partner. SSMH's experience working with MCOs on providing care management, wraparound services, innovative services, and integrated care will also be an asset in communicating our skills and expertise as well as presenting a strong case for the value and benefits of creating ACO partnerships. In addition, SSMH has established working relationships with several potential ACOs in the Quincy service areas. SSMH is currently working with Steward Health Care Systems primary care practices in Quincy as well as in the nearby communities of Dorchester, New Bedford, Fall River, Wareham, and Brockton. Services are provided through a contract with Quartet Inc., a software company that provides a communication platform to facilitate rapid referrals between PCPs and BH providers.

SSMH has also been working with Steward's Hawthorn Medical in North Dartmouth to provide co-located services in the primary care practice, including screening, diagnostic evaluation, short-term treatment and referral, medication management, and psychopharm consultation to the PCPs. Using Quartet, SSMH provides preferred access, real time communication and coordination between PCPs and SSMH's Quincy and Wareham clinics. Physicians initiate service requests through the Quartet platform, which connect directly with SSMH clinicians, who then respond directly to physician requests at intake and provide treatment and care coordination updates on a regular basis. All clients are administered outcome instruments on admission and at six months that include the Patient Health Questionnaire-9 (PHQ9) for depression screening and the Alcohol Use Disorders Identification Test (AUDIT) for SUD.

2. Branding and Marketing Plans

SSMH and Spectrum will develop a specific marketing strategy focused on prospective member engagement. Specific methodologies will include direct mail with a letter and brochure to members' homes introducing the BH CP Care Coordinators. The initial letter will state supports that the BH CPs offer, including existing SSMH and Spectrum programs addressing basic client needs. The letter will also reference and promote the affiliated ACOs and MCOs.

SSMH is uniquely positioned to provide additional supports to clients through two established philanthropic funds. The Linburn Fund provides grants to clients to assist with long-term goals, including education, social skills and independence. The Client Basic Needs Fund provides funding for urgent basic needs, including food, shelter and clothing. These funds are accessed through clinician referral and managed by SSMH's Marketing and Development Department. SSMH supporters have donated to these funds.

A direct mail piece will include an incentive of a $10 gift card upon completion of an initial assessment with the Care Coordinator. The gift card will be for a store where the client can access healthy food or clothing. This mailing will be followed up with a phone call from the Care Coordinator within a week of delivery. A follow-up mailing will be sent to Assigned Enrollees who have not responded to the initial mailing, two weeks later, along with the same incentive. If the member does not make contact after receipt of the two mailings, the Care Coordinator will call again. If an email address is available, the same information will be sent via email.

3. Collaboration with Multiple ACOs and MCOs

SSMH has working partnerships that bridge health care to promote collaborative, comprehensive and holistic care for MassHealth members. SSMH has affiliation agreements and contractual relationships with care providers in the Quincy Service Area, including BID-Milton, South Shore Health System, and Steward Health System. We are improving our clients' level of wellness by increasing access to care coordination and management while delivering cost-effective and non-duplicative services. SSMH is improving clients' experience with the health care system; reducing costs; and providing the right care at the right time in the lowest cost setting. We share health care information with our community partners in real time.

SSMH will be joining Steward Health Care System's ACO Referral Circle, building upon the existing partnership. As a BH CP, the collaboration with Steward would facilitate referrals, access, service coordination, and service delivery. SSMH is in final negotiations with Signature Health System to embed staff. SSMH is currently working with Manet and SSH, which are included in the Boston Medical Center ACO. SSMH clinicians are located at the SSH ED to facilitate assessment, coordination and engagement of presenting patients. SSMH also provides co-located clinical and care management services at Manet clinics. This experience with Manet in attributing Medicaid clients for care management is transferrable to the BH CP. SSMH also intends to contract with Tufts Health Public Plan, which is the ACO for BID health system.

The engagement and communication with ACOs and MCOs will be coordinated by the BH CP's Governing Body with input from the Consumer Advisory Board. Service coordination is in place with many ACOs through existing clinical and care management relationships with PCPs, hospitals, EDs, and administrators. SSMH and Spectrum will further develop these referral relationships, care coordination and clinical pathways through the evolving community and health system partnerships.

4. Conflict Resolution with MCO or ACO

Conflict resolution with the ACOs or MCOs will occur on the service delivery level utilizing the Care Managers and Program Managers. Conflict resolution on the administrative level will be reviewed and managed by the Governing Body.

Community Partner Program Budget Report

SSTAR Community Partner

Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Estimated Enrollees- Start of Period (All Enrollees)		1,000	3,000	3,500	4,500	5,000	
Estimated Enrollees - End of Period (All Enrollees)		3,000	3,500	4,500	5,000	5,000	
Estimated Enrollees - Monthly Average (excl CBFS enrollees)		2,300	2,990	3,680	4,400	4,660	
Estimated Enrollees - Monthly Average (CBFS enrollees only)		200	260	320	320	340	
Estimated Program Revenue (excl CBFS enrollees)		$ 2,898,000	$ 6,458,400	$ 7,948,800	$ 9,504,000	$ 10,065,600	$ 36,874,800
Estimated Program Revenue (CBFS enrollees only)		$ 350,000	$ 780,000	$ 960,000	$ 960,000	$ 1,020,000	$ 4,070,000
Total Estimated Program Revenue		**$ 3,248,000**	**$ 7,238,400**	**$ 8,908,800**	**$ 10,464,000**	**$ 11,085,600**	**$ 40,944,800**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -	$ -	$ -	$ -
Revenue for Operations		**$ 3,248,000**	**$ 7,238,400**	**$ 8,908,800**	**$ 10,464,000**	**$ 11,085,600**	**$ 40,944,800**

	Program Expenses		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
1	**Salary**		$ 128,414	$ 1,899,948	$ 4,047,908	$ 4,893,761	$ 5,705,780	$ 6,021,566	$ 22,697,377
2	**Fringe**		$ 25,683	$ 379,990	$ 809,582	$ 978,752	$ 1,141,156	$ 1,204,313	$ 4,539,476
	Total Personnel Costs		$ 154,097	$ 2,279,938	$ 4,857,490	$ 5,872,513	$ 6,846,936	$ 7,225,879	$ 27,236,853
3	**Training & Professional Development**		$ -	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 50,000
4	**Travel**		$ 3,770	$ 58,126	$ 129,537	$ 159,430	$ 188,127	$ 199,288	$ 738,278
5	**Equipment**			$ 2,800	$ 4,800	$ 4,800	$ 4,800	$ 4,800	$ 22,000
6	**Supplies**		$ -	$ 123,349	$ 211,456	$ 211,456	$ 211,456	$ 211,456	$ 969,173
7	**Contract Services** (consulting, professional)		$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	**Software licensing**			$ 99,900	$ 126,900	$ 153,900	$ 179,820	$ 189,900	$ 750,420
9	**Telecommunications**			$ 43,750	$ 71,700	$ 83,400	$ 94,632	$ 99,000	$ 392,482
10	**Occupancy** (rent, utilities, maintenance)		$ 5,993	$ 32,807	$ 56,240	$ 56,240	$ 56,240	$ 56,240	$ 263,760
11	**Other**		$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Total Direct Costs		$ 163,860	$ 2,650,669	$ 5,468,123	$ 6,551,739	$ 7,592,011	$ 7,996,563	$ 30,422,965
12	**Indirect Cost/Administrative Overhead**	0.0%	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	$ -
	TOTAL EXPENSES		$ 163,860	$ 2,650,669	$ 5,468,123	$ 6,551,739	$ 7,592,011	$ 7,996,563	$ 30,422,965
	Surplus/Shortfall		*$ (163,860)*	*$ 597,331*	*$ 1,770,277*	*$ 2,357,061*	*$ 2,871,989*	*$ 3,089,038*	*$ 10,521,835*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Program Director	$ 155,000.00	0.5	7	$ 45,208
MV Supervisory staff	$ 45,673.33	0.2308	1	$ 878
MV Clinical Care Manager (RN)	$ 50,223.33	0.2308	1	$ 966
MV Care Coordinator	$ 29,770.00	0.2308	1	$ 573
				$ -
				$ -
FHR Supervisory staff (1 hr pr wk plus train	$ 87,627.11	0.05527	7	$ 2,825
FHR Clinical Care Manager (RN)	$ 43,333.33	0.2308	1	$ 833
FHR Care Coordinator (2 ppl)	$ 32,500.00	0.4616	1	$ 1,250
				$ -
GNBCHC Clinical Care Manager (RN)	$ 72,857.14	1	7	$ 42,500
GNBCHC Care Coordinator	$ 37,250.00	0.4616	1	$ 1,433
				$ -
Health First Clinical Care Manager (RN)	$ 72,862.00	0.3227	7	$ 13,716
SSTAR Clinical Care Manager (RN, 4ppl)	$ 62,000.00	0.9228	1	$ 4,768
SSTAR Care Coordinator (20ppl)	$ 35,000.00	4.616	1	$ 13,463
				$ -
				$ -
Total Salary (Program Budget Line 1)		**9.26317**		**$ 128,413.78**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe	Fringe
Fringe Item	$ 128,413.78	20%	$ 25,683
Total Fringe (Program Budget Line 2)			**$ 25,683**

Total Personnel*	**$ 154,097**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

The program director will will provide day-to-day management, ensure that contract deliverables are met and coordinate with affiliate partners and materials subcontractor to plan the ramp up to (and eventual delivery of) CP services.
Martha's Vineyard is dedicating 40 hours of time for a supervisory staff, clinical care manager, and care coordinator to attend SSTARs prep period training for staff. This training will provide staff who will be starting June 1 with all the information they need on workflows, utilization of the EHR, quality metrics etc that they need to know in order to do their jobs come June 1. 40 hours of work for staff translates to .2308 FTE in a single month, hence the numbers above.
Fellowship will be providing a clinical care manager and 2 care coordinators to attend the 40 hour training. Additionally they'll send one supervisory staff member who will also act as the liason for the project averaging around 1 hour per week to the various needs of the CP grant. Additionally they're dedicating 7 hours of staff time for a Board Member to attend the monthly governance meetings SSTAR will be putting on.
GNBCHC will be sending a clinical care manager and care coordinator to the training, and the clinical care manager will additionally act as the main liason/support staff for all necessary ramp-up activities for the organization.
Health First will also be providing a clinical care manager to attend the training and manage all ramp-up liason activities
SSTAR will be sending 20 Care Coordinator staff and 4 RNs to the 40 hours of training. These are staff that already work in other parts of the agency as FFS but who are prepared to transition to the CP grant as needed given the number of enrollees.

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Total Training and Professional Development (Program Budget Line 3)			

Provide a description of each Training and Professional Development line item included in the table above:

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
MV: Supervisory Staff for governance	120	3	0.535	$ 192.60
MV Supervisory staff for training	120	2	0.535	$ 128.40
MV: Clinical care Manager - RN	Same car as superv.	0	0	$ -
MV: Care Coordinator	Same car as superv.	0	0	$ -
Fellowship: Supervisory staff for governan	50	7	0.535	$ 187.25
Fellowship: Supervisory staff for training	75	2	0.535	$ 80.25
Fellowship: Clinical care Manager - RN	75	2	0.535	$ 80.25
Fellowship: Care Coordinator	75	2	0.535	$ 80.25
Fellowship: Care Coordinator	75	2	0.535	$ 80.25
			Total Mileage	$ 829.25

Travel Expense Description	Cost
Total Mileage	$ 829.25
Parking and tolls	
Public transportation (ferry)	$ 499.00
Hotel for MV staff	$ 1,380.00
Per Diem for MV staff	$ 1,062.00
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ 3,770.25**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

Martha's Vineyard will be sending a supervisory staff member, an RN, and a Care coordinator to two separate trainings hosted by SSTAR. These staff will carepool together for an estimated 120 miles round trip at .535/mile for 1 car for 2 trips (two trainings), for a total of $128.40. The cost of the ferry auto reservation for 1 car includes passenger tickets and will be $217 total for these trips. A meal allowance of $59/day for 3 staff for 3 days for two sets of trainings will be $1,062, and hotel for 3 rooms for 2 nights at $115 per night include taxes/fees will be 1,380 for two trips.

Additionally Martha's Vineyard will contribute one governance committee representative who will attend 3 of the monthly meetings in person (the rest by phone) Ferry auto reservation for those 3 trips at $94 per trip is $282, Mileage to/from Fall River @ 120 miles round trip @ .535/mile for 3 trips is $192.60

Total milage for MV for the trainings and meetings is: $321 for 600 miles (5 trips)
Total ferry cost for MV for the trips is: $499
Total cost for travel for MV including hotel and per diem is: $4,000

Fellowship will be sending 1 supervisory staff member, an RN, and 2 Care coordinators to SSTAR for trainings. 50 miles round trip at $.42/mile for 4 staffis $84 for 3 trips is $252. 3 trips in 2 months averages to 75 miles a month in trips (150 miles in 2 months)
Fellowship will send one Governance Committee Rep to attend 7 meetings (1 per month) for $147 in total milage costs
Total cost for travel for Fellowship: $399
Total travel costs: $3,770.25

Row 5 - Equipment

Description of Equipment	Unit Cost or Cost/FTE	#units or FTEs	Cost
Total Equipment (Program Budget Line 5)			

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Total Supplies (Program Budget Line 6)			

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
		Total Software Licensing (Program Budget Line 8)	

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
		Total Telecommunications (Program Budget Line 9)	

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent	3515	10	$ 35,150.00
Utilities			$ -
Repair and Maintenance			$ -
Pro-rate for several months rent in PBY			$ (29,157.00)
			$ -
		Total Occupancy (Program Budget Line 10)	**$ 5,993.00**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

3 large areas with 15 cubicles each 7 offices for individual staff Reception/admin area with two seats 1 meeting room that would accommodate 15-20 people, kitchen/lounge area, space will be rented, so annual cost at $10/SqFT will be 35,150 or approx. 2929/month however space will not be rented out until April/May of 2018 so $5858 for two months brought up to $5993 to account for variances in pro-rate rate for partial month depending on day we sign lease.

Row 11 - Other

Other Direct Expense Description	Cost
Total Other (Program Budget Line 11)	

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)		

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Community Partner Infrastructure Budget Report

	SSTAR Community Partner						
Infrastructure Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
PMPM Infrastructure Rate		$ 100.00	$ 86.05	$ 51.49	$ 45.40	$ 39.28	
Engaged Enrollees		3,000	3,000	3,500	4,500	5,000	
Estimated Infrastructure Funds		$ 2,100,000	$ 3,097,800	$ 2,162,580	$ 2,451,600	$ 2,356,800	**$ 12,168,780**
At- Risk Withhold Rate			25%	44%	63%	81%	
Withhold			$ 774,450	$ 951,535	$ 1,544,508	$ 1,909,008	**$ 5,179,501**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 2,100,000	$ 2,323,350	$ 1,211,045	$ 907,092	$ 447,792	**$ 7,439,279**

	Infrastructure Investment Projects		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
	Technology								
1	**IT Staffing including Fringe**		20169	$ 175,980	$ 301,680	$ 301,680	$ 301,680	$ 301,680	**$ 1,402,869**
2	**Development Adaptation of EHR and/or Care Management System**		$ 175,000	$ 50,000	$ 25,000	$ 25,000	$ 25,000	$ 25,000	**$ 325,000**
3	**Technology for Service Delivery**		$ 10,478	$ 100,500	$ 32,250	$ 32,250	$ 31,080	$ 13,920	**$ 220,478**
4	**Other Technology Expenses**		$ -	$ 109,830	$ -	$ -	$ -	$ -	**$ 109,830**
	Total Technology		$ 205,647	$ 436,310	$ 358,930	$ 358,930	$ 357,760	$ 340,600	**$ 2,058,177**
	Workforce Development								
5	**Workforce Development staffing including Fringe**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
6	**Recruitment Expenses**		$ 1,010	$ 2,950	$ 1,800	$ 1,250	$ 800	$ 800	**$ 8,610**
7	**Training Expenses**		$ 7,500	$ 161,000	$ 161,000	$ 160,500	$ 160,500	$ 160,500	**$ 811,000**
8	**Retention Expenses**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Workforce Development		$ 8,510	$ 163,950	$ 162,800	$ 161,750	$ 161,300	$ 161,300	**$ 819,610**
	Business Start Up Costs								
9	**Office Equipment (PBP & BP1 only)**		$ -	$ -					**$ -**
10	**Office Furniture (PBP & BP1 only)**		$ -	$ 237,632.00					**$ 237,632**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**		$ 163,860	$ -	$ -	$ -			**$ 163,860**
	Total Business Start Up Costs		$ 163,860	$ 237,632	$ -	$ -			**$ 401,492**
	Operational Infrastructure								
12	**Operation Staffing including Fringe**		$ 27,840	$ 35,583	$ 61,000	$ 61,000	$ 61,000	$ 61,000	**$ 307,423**
13	**Other Operational Expenses**		$ 4,166	$ 3,465	$ 3,465	$ 3,465	$ 3,465	$ 3,465	**$ 21,491**
	Total Operational Infrastructure		$ 32,006	$ 39,048	$ 64,465	$ 64,465	$ 64,465	$ 64,465	**$ 328,914**
14	**Indirect Cost/Administrative Overhead Rate**	9.8%	$ 39,977	$ 85,502	$ 57,154	$ 57,052	$ 56,894	$ 55,221	**$ 351,799**
	TOTAL INVESTMENTS		**$ 450,000**	**$ 962,441**	**$ 643,349**	**$ 642,197**	**$ 640,419**	**$ 621,586**	**$ 3,959,991**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Network Application IT specialist	$ 86,400.00	0.41	5.8	$ 17,122
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary			$ 17,122
	Fringe rate	17.8%	Total Fringe	$ 3,048
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 20,169**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

The Network IT specialist will work with GNBCHC to aid the organization in IT development and sharing of information associated with the member population.

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
eHana Care Management System Implementation	$ 175,000.00

	A	B	C	D	E	F	G
34							
35							
36							
37							
38							
39	**Total Development and Adaptation of EHR and Care**						
40	**Management System**	$ 175,000.00					
41	**(Infrastructure Budget Line 2)**						
42							
43	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's***						
44	***contract and how the costs were determined:***						
45							
46	***The ehana Care Management System will be utilized for all affiliated partners to document their activities, outreach efforts, care***						
47	***plans, care plan sign offs etc. It will be the central system utilized in managing the day to day work of the grant. The ehana***						
48	***system will also produce management reports for care teams and affiliated partners to monitor the activities of their individual***						
49	***care coordination staff, identify when enrollees are due for outreach, run reports on the quality measures required of the***						
50	***Community Partner grant, and manage the billing between the SSTAR CP and Massachusetts.***						
51							
52							
53							
54							
55							
56							
57							
58	**Row 3 - Technology for Service Delivery**						
59	**Description of Expense**	**Cost**					
60	3 Laptops for Fellowship	$ 7,240.39					
61	PCs for Martha's Vineyard (including delivery and setup	$ 3,238.00					
62							
63							
64							
65							
66	**Total Technology for Service Delivery**	**$ 10,478.39**					
67	**(Infrastructure Budget Line 3)**						

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Fellowship will be purchasing 3 laptops for their staff to utilize in documenting activies for the CP grant. MV will be purchasing PCs for their team to do the same.
The laptops, Dell Latitude E7470, are $130 for a monitor and $170 for a docking station and $2100 for the laptop.
2PCs for MV at 1600 each, including monitor and shipping to MV

Row 4 - Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses (Infrastructure Budget Line 4)	

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner <u>Infrastructure</u> Budget Report - Workforce Development - Year 1

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -

Total Salary	0		$	-	
Fringe rate	20.0%	Total Fringe	$	-	
Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)			**$**	**-**	

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 6 - Recruitment Expenses

Description of Expense	Cost
Advertising in the local papers and on-line for additiona	$ 1,010.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 1,010.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Martha's vineyard and Fellowship will both be dedicating resources to recruitment towards obtaining additional staff. MV is budgeting $912 and Fellowship is budgeting $98

Row 7 - Training Expenses

Description of Expense	Cost
Development of training program for pre-go live trainin	$ 7,500.00
Total Training Expenses (Infrastructure Budget Line 7)	

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

SSTAR intends to engage a consultant to develop a training course to be administrated to all staff in preparation of go live on June 1. Course will include workflows, utilization of eHana software, role responsibilities, metrics, and required services. 75 hours at $100/ hr for a consultant to develop/prep/conduct training

Row 8 - Retention Expenses

Description of Expense	Cost
Total Retention Expenses (Infrastructure Budget Line 8)	

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Business Start Up Costs - Prep Budget Period

Row 9 - Office Equipment

Description of Expense	Cost
Total Office Equipment (Infrastructure Budget Line 9)	

Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were determined:

Row 10 - Office Furniture

Description of Expense	Cost

	A	B
270		
271	**Total Office Furniture**	
272	**(Infrastructure Budget Line 10)**	

Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Data Director	$ 87,000.00	0.35	2	$ 5,075.00
Data Director	$ 87,000.00	0.5	5	$ 18,125.00
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -

Total Salary	0.85		$	23,200.00	
Fringe rate	20.0%	Total Fringe	$	4,640.00	
Total Program Staffing including Fringe (Infrastructure Budget Line 12)			**$**	**27,840.00**	

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

The data directior will conduct data analysis for the CP program and ensure all data associated with the project are gathered and reported in a timely manner. The data director is responsible for monitoring and reporting on all quality and performance metrics. Additionally the data director serves as a back-up point of contact to the project director for communications/management of the affiliated partners and the state. The data director will be at .35 FTE for November and December, and .5 FTE as the new care management system eHana gets up and running and ramp up activities/preparation increase. Technically the data director averages out at 0.4571428571428571 FTEs for the full 7 months but it seemed easier to break it into two lines.

Row 13 - Other Operational Expenses

Description of Expense	Cost
Administrative costs for contract for MV	$ 1,444.00
Administrative costs for contract for Fellowship	$ 2,021.00
FHR Governance Board Member	$ 701
Total Other Operational Expenses (Infrastructure Budget Line 13)	**$ 4,165.50**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Martha's Vineyard and Fellowship are allocating a portion of their DSRIP funding toward administrative contract costs for $1,444 and $2,021 respectively. Additionally Fellowship will be dedicating an hour a month for a governance board member to attend monthly meetings (was advised by MassHealth to add this here, not to program budget)

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**9.80%**	**$ 39,977.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined: Indirect/Admin costs are expected to adjust in future years however this preliminary funding will be utilized for general overhead costs and the time of the CEO and COO participating in a number of activities in preparation for ramp-up

	A	B	C	D	E	F	G
367							
368							
369							
370							
371							
372							
373							

Community Partner Infrastructure Allocation Worksheet

	SSTAR Community Partner						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 2,100,000	$ 2,323,350	$ 1,211,045	$ 907,092	$ 447,792	$ 7,439,279
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
New Bedford CHC	$ 20,169	$ 80,580	$ 110,130	$ 110,130	$ 109,896	$ 106,464	$ 537,369
Martha's Vineyard	$ 3,238	$ 5,025	$ 1,613	$ 1,613	$ 1,554	$ 696	$ 13,738
Healthfirst	$ -	$ 5,025	$ 1,613	$ 1,613	$ 1,554	$ 696	$ 10,500
Fellowship	$ 7,240	$ 5,025	$ 1,613	$ 1,613	$ 1,554	$ 696	$ 17,740
SSTAR	$ 175,000	$ 340,655	$ 243,963	$ 243,963	$ 243,202	$ 232,048	$ 1,478,830
Total Technology	$ 205,647	$ 436,310	$ 358,930	$ 358,930	$ 357,760	$ 340,600	$ 2,058,177
Workforce Development							
New Bedford CHC		$ 500	$ 500	$ -	$ -	$ -	$ 1,000
Martha's Vineyard	$ 912	$ 950	$ 950	$ 950	$ 500	$ 500	$ 4,762
Healthfirst		$ 250	$ 250	$ 200	$ 200	$ 200	$ 1,100
Fellowship	$ 98	$ 250	$ 100	$ 100	$ 100	$ 100	$ 748
SSTAR	$ 7,500	$ 162,000	$ 161,000	$ 160,500	$ 160,500	$ 160,500	$ 812,000
Total Workforce Development	$ 8,510	$ 163,950	$ 162,800	$ 161,750	$ 161,300	$ 161,300	$ 819,610
Business Start Up Costs							
New Bedford CHC	$ 52,720	$ -	$ -	$ -	$ -	$ -	$ 52,720
Martha's Vineyard	$ 6,162	$ -	$ -	$ -	$ -	$ -	$ 6,162
Healthfirst	$ 16,459	$ -	$ -	$ -	$ -	$ -	$ 16,459
Fellowship	$ 6,399	$ -	$ -	$ -	$ -	$ -	$ 6,399
SSTAR	$ 82,120	$ 237,632	$ -	$ -	$ -	$ -	$ 319,752
Business Start Up Costs	$ 163,860	$ 237,632	$ -	$ -	$ -	$ -	$ 401,492
Operational Infrastructure							
New Bedford CHC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Martha's Vineyard	$ 1,444	$ 1,444	$ 1,444	$ 1,444	$ 1,444	$ 1,444	$ 8,664
Healthfirst	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fellowship	$ 2,722	$ 2,021	$ 2,021	$ 2,021	$ 2,021	$ 2,021	$ 12,827
SSTAR	$ 27,840	$ 35,583	$ 61,000	$ 61,000	$ 61,000	$ 61,000	$ 307,423
Operational Infrastructure	$ 32,006	$ 39,048	$ 64,465	$ 64,465	$ 64,465	$ 64,465	$ 328,914
TOTAL INVESTMENTS	$ 410,024	$ 876,940	$ 586,195	$ 585,145	$ 583,525	$ 566,365	$ 3,608,193

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Development and Adaptation of E.H.R/Care Management System	Get SSTAR and partners up and running, on eHana Care management platform	11/01/17	05/15/18	Be utilizing demo/test environment of system and finalizing workflows	Admin or Development login to working version of eHana product			All starting staff trained on system w/ logins	Training conducted, logins for system distributed, help line for staff questions established		
Technology												
Technology												
Technology												
Workforce Development	Training Expenses	Engage consultant and develop training materials for 2 training workshops	11/01/17	05/31/18	Training materials in final review, training dates established	Training materials in final stages and dates scheduled for training			Initial training session complete, schedule for future trainings of new staff established	Regular schedule for new trainings in place		
Workforce Development												
Workforce Development												
Workforce Development												
Business Start Up Costs	Ramp-up Costs	Identify location/space for CP staff	01/01/18	05/31/18	Have several prospects for rental spaces available with quotes	Have several prospects for rental spaces available with quotes			Identify rental space for staff and be getting ready to move in	Lease in process		
Business Start Up Costs												
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Ramp-up Costs	Establish Governance Committee, Quality Committee, and Consumer Advisory Board	10/15/17	12/01/17	Several meetings Governance Committee conducted, at least one meeting for the other two committees conducted	Member roster for each committee, meetings scheduled			Regular schedule established for all committee meetings moving forward	Regular schedule communicated for all committee meetings moving forward		
Operational Infrastructure												
Operational Infrastructure												
Operational Infrastructure												

BH Community Partner - Staffing Model

Insert Contractor Name Here

line #			
1	Estimated number of Engaged Enrollees (including CBFS if applicable) at the end of Budget Period 1	3000	*Should align with Program Budget*

	BH CP Program Staff	FTEs (Do not duplicate FTE - FTE's may be allocated across staffing positons as applicable)	Comment
2	BH CP Director and Assistant/Deputy Director	0.5	*Total management oversight of BH CP*
3	Medical Director	0.5	*Portion of Medical Director allocated to BH CP for the number of enrollees shown in line 1*
4	RNs		
5	Clinical Care Managers (RN)	12	*Do not include FTEs listed in line 4*
6	Clinical Care Managers (LPHA)	3	*LPHA includes LICSW, LMHA, LADC I*
7	Supervisors/Team Leaders	3	*Do not include FTEs listed in lines 4, 5 or 6*
8	Other Licensed Staff		*Do not include FTEs listed in lines 4, 5, 6 or 7*
9	Care Coordinators	60	*FTEs providing Care Coordination (may include Health Outreach Workers, Community Health Workers, Peer Specialists, Recovery Support Navigators providing care coordination)*
10	Peer Specialist/ Recovery Coaches (non-Care Coordination)		*Do not include FTEs of Peer Specialists or Recovery Coaches included in line 9*
11	Intake Coordinators/Engagement Specialists		
12	Administrative Support	1	
13			
14			
	Total FTE	80	

	Staff Ratios - Please calculate the following ratios:		
15	Ratio of RN and Clinical Care Manager (RN) to Assigned and Engaged Enrollees	1:250	*Estimated number of Assigned and Engaged Enrollees at the end of BP1 divided by total FTEs of (RN+RN Clinical Care Managers)*
16	Ratio of Care Coordinator Supervision to Care Coordinators	1:20	*Total Care Coordinator FTEs divided by Total Care Coordination Supervision FTEs*

Please describe which Program staff listed in lines 2 through 8 above directly supervise Care Coordinator staff: Supervisors will be liscensed behavioral health clinicians and each will supervise 20 care coordinators

Section 7.3 Initial DSRIP Participation Plan

A. Executive Summary

1. Goals, identified challenges related to the care delivery system and behavioral health, and proposed solutions to be effectuated through the CP program.
The goals for our Community Partners program are 1) to establish a network of strategic partners to address factors that contribute to high utilization of health services and 2) to improve health and social outcomes for enrollees through an integrated patient-centered care model. SSTAR will partner with a diverse group of organizations such as hospitals, health centers, community-based organizations, housing programs, homeless shelters, private practitioners, and local government entities to achieve these goals. The roles of these strategic partners are varied; they range from affiliated partnerships, which will deliver CP services, to referral organizations that will address social needs such as transportation, housing, food etc. SSTAR plans to implement a variety of evidence-based approaches to improve health and social outcomes for enrollees, including care coordination and management, integration of care, and addressing unmet social needs.

The challenges we currently face in the delivery of care to SMI/SUD patients are unmet social needs (i.e., transportation and housing), coordinating care among multiple providers, lack of insurance due to churn, and stabilization/self-management. Studies have found that addressing a patient's basic resource needs such housing, transportation, and food can significantly improve health outcomes. A recent study by Harvard Medical School researchers at Massachusetts General Hospital found that addressing the social needs of hypertensive patients significantly reduced their blood pressure compared to patients whose needs were not addressed. A pilot project by Kaiser Permanente found that among its high utilizers, unmet social needs was quite prevalent. Based on these and other similar findings, SSTAR and its project partners will place emphasis on addressing unmet social needs to improve health outcomes among enrollees.

A major contributor to poor health outcomes is when patients have multiple providers that are not aware of one another and/or communicate with one another. Our care coordinators will work with enrollees to identify all health and social providers involved in their care. We will work extensively with internal departments and external partners to facilitate communication and collaboration around service delivery so as to reduce duplication of services. Our Behavioral Health Community Partners program will strengthen collaborations with local hospitals so that we can receive daily reports on enrollees who use the ER for non-emergency visits. We also want the hospitals to include us in discharge planning to ensure continuity of care for our enrollees after they have been discharged from the hospital. These types of collaborations will help us to decrease unnecessary health care costs and improve health outcomes for enrollees.

Among residents surveyed for our 2016 Community Health Needs Assessment, 30% reported being uninsured. The most common reason identified for lack of insurance among these individuals is "churn" meaning that they were disenrolled from MassHealth for failing to renew the annual application. Many patients forget that they have to renew their MassHealth

insurance annually. When they fail to complete the renewal application, they often lose coverage and have to start the process over again. Through the BH CP program, we will have care coordinators work with the outreach and enrollment navigators to reduce churn and increase stable insurance coverage. We will make it possible for outreach staff to enroll/re-enroll individuals during community outreach. We will provide laptops for all outreach and enrollment navigators that will allow them to access the Health Connector in during community outreach.

Self-management and stabilization is an important component of care management. One of our outcomes for this project is to have enrollees take charge of their health. We will do this by working collaboratively with enrollees to develop a treatment plan, identify unmet social needs, and provide health and wellness events.

2. The number of Assigned and Engaged Enrollees the Bidder intends to support under the Contract

SSTAR, in collaboration with its affiliated partners and material subcontractor, intends to serve 5,275 enrollees.

3. The Service Areas for which the Bidder is bidding

SSTAR has selected to serve six service areas in the southern region; these are Fall River, Attleboro, New Bedford, Oak Bluffs, Taunton, Barnstable, Falmouth, Orleans, and Wareham.

4. The Bidder's plans to operationalize the CP program and time frames associated with implementing such activities.

Table 3: CP Operational Plan

Period	Activities	Time Frames
Preparation Budget Period	Convene initial BH CP governing committee meeting	November 2017
	Recruit for vacant positions	March 2018- and ongoing
	Recruit CAB members	
	Establish CP Quality Management Committee	Nov 2017- June 2018
	Conduct infrastructure improvements	
	Establish policies and procedures for BH CP	
	Submit Readiness Review to EOHHS	
Budget Period 1	Implement care coordination services	June -Dec 2018
	Conduct orientation and training for care coordinators	
	Conduct quarterly meetings of CAB & QM Committee	
	Develop annual quality improvement plan	
Budget Period 2	Conduct marketing to ACOs and MCOs	Jan-Dec 2019
	Conduct annual trainings for care coordinators	
	Conduct CP program evaluation	
	Revise program services based on evaluation findings	
Budget Period 3	Identify new community partners for referrals	Jan-Dec 2020
Budget Period 4	Continuity of BH CP services	Jan- Dec 2021
Budget Period 5	Conduct outreach to ACOs and MCOs	Jan- Dec 2021

B. Supporting Populations and Community Engagement

1. Connections to the community, including current and planned collaborations and partnerships with community-based organizations.

SSTAR has grown from a 20-bed alcohol detox organization, with an annual budget of less than one million, to a $26 million integrated addiction, mental health, primary care, social service organization with two locations in Fall River. Most services are available at SSTAR's 386 Stanley Street campus. At our more recently-established south end location, 1010 South Main Street, SSTAR operates the Lifeline methadone program, a satellite site for SSTAR's Family Healthcare Center and outpatient behavioral health counseling.

The Fall River organizations with which we collaborate are as follows: Department of Mental Health's new ESP provider for the Fall River area, Boston Medical Center working with Bay Cove, and Vinfen. SSTAR has had long and collaborative relationships with the two hospital systems: Southcoast and Steward. SSTAR subcontracts with Steppingstone—the leading provider of halfway house services in the area—for residential addiction services under our Federal Probation contract. SSTAR currently collaborates with the Fellowship Health Resources to provide substance abuse training, consultation, and direct treatment services to FHR staff and the residents of their community homes in Fall River.

ATTLEBORO

SSTAR's Opioid Triage Center is one of three in the state with a service area of Southeastern Massachusetts, including Attleboro. SSTAR's OTC aims to utilize technology to overcome some of the geographic barriers facing individuals and families affected by the opioid epidemic. SSTAR plans to reach out to social service organizations such as On Common Ground, the Salvation Army, and others that address the social/economic needs of residents. SSTAR works with Attleboro police on overdose prevention. We have a regular referral system with Arbor hospital and utilize a shared medical director for our dual diagnosis unit.

NEW BEDFORD

For several years, SSTAR has been providing substance abuse screening, brief intervention, and case management at the New Bedford Court. In 2015, SSTAR was selected by the Bristol County District Attorney to implement the Drug Court program at the New Bedford Court. SSTAR also has a long-standing contract with Positive Action Against Chemical Addiction of New Bedford to transport its patients to SSTAR for detox admission. As part of the referral network to be established in New Bedford, we plan to collaborate with food pantries such as Mercy Meals and More, organizations addressing domestic violence such as the New Bedford Women's Center for domestic violence, and Catholic Social Services.

TAUNTON

For the past three years, SSTAR has managed an opiate abuse prevention initiative in Taunton funded under a grant from the Bureau of Substance Abuse Services (BSAS). Taunton is one of the service areas for two other addiction prevention grants managed by SSTAR: Massachusetts Opiate Abuse Prevention Collaborative (MOAPC) and Substance Abuse Prevention Collaborative (SAPC). Under the SAPC initiative, SSTAR implements underage

drinking and drug prevention activities in Taunton, Fall River, Dighton, and Norton. Since 2015, the city of Taunton has subcontracted with SSTAR to manage the grant activities associated with their Department of Public Health Bureau of Substance Abuse Services and Partnership for Success grant. The project targets youth prescription drug abuse.

WAREHAM
SSTAR currently serves residents of Wareham and plans to collaborate with the Greater New Bedford Community Health Center. In addition, we will seek referral relationships with Damien Place Food Pantry and Evergreen House, a recovery-housing program.

BARNSTABLE, FALMOUTH, ORLEANS
SSTAR's Opioid Triage Center (BSAS-funded Opioid Urgent Care Center) is one of three in the state with a service area of Southeastern Massachusetts, including the Cape and Islands. SSTAR's OTC aims to utilize technology to overcome some of the geographic barriers facing individuals and families affected by the opioid epidemic. SSTAR is collaborating with Fellowship Health Resources to serve residents in this service area. We plan on establishing referral relationships with shelters such as Angel House and Carriage House, as well as with food pantries such as Nam Vets Association of Cape and Islands Pantry, and the Falmouth Service Center Community.

OAK BLUFFS
In October of 2016, SSTAR entered into an agreement with Martha's Vineyard Community Services and Martha's Vineyard Hospital to reduce opiate overdoses on the island by improving access to detox and care coordination for MV residents. The agreement calls for expedited referral and admission to detox at SSTAR and makes provisions for MVCS Recovery Coach accompaniment of the patient to Fall River, as well as provisions for communication between detox counseling staff and MVCS Recovery Coaches. Our partner MVCS operates a thrift shop providing no-cost items to those in need, and we plan on including Vineyard House, sober- housing, and transportation services through the Lift Van Service and Medivan.

2. How SSTAR will grow its connections to the community in the Service Areas.
SSTAR plans on implementing the following strategies to grow our connections to the service areas we have identified. In collaboration with our affiliated partners and material subcontractor, we plan on identifying new referral resources in order to have a wide array of supportive services that can be offered to our enrollees. We also plan on making some of the trainings we conduct, such as opioid overdose prevention, available to community organizations in the service areas that may need this skill.

3. Plans to ensure staff is informed of community resources over the course of the Contract Term.
SSTAR will develop a secure intranet from its webpage that will allow all care coordinators to find up-to-date information on community resources. Information on housing, transportation, food pantries, etc. will be listed by geographic region. This resource site will also include a monthly calendar of dates of wellness events across the selected service areas.

C. Community Partner Supports and Activities

1. Outreach and Active Engagement

1.a. Planned strategies for outreaching to and engaging with Assigned Enrollees, including individuals who are homeless and hard to reach

SSTAR has employed a wide range of outreach strategies to successfully conduct follow-up among the challenging populations targeted by our many SAMHSA demonstration grants as well as by the studies conducted through our Research Department. We expect that our experience in this regard will be an asset in developing and implementing successful outreach protocols for the BH CP initiative. Initial outreach to referred members will be through phone. It is common for people to change mobile phone numbers or have phone service cut off/run out of minutes. Depending on what information is provided in the referral from EOHHS or the ACO, lack of success with voice phone contact could lead to efforts to contact via email or text. Phone messages, email, and text will be carefully utilized and omit personal information, to protect the individual's privacy. Depending on case information provided, it may make sense to conduct online searches such as checking prison databases and Googling the person.

Once contact has been made and enrollment takes place, the individual will be asked to authorize the BH CP project to contact them through identified "locator" contacts (significant other, parent, child, or friend). They will also be asked to provide explicit consent for the care coordinator to reach out to them through Facebook. Several years ago, SSTAR's Research Department received IRB approval to implement a HIPAA-compliant outreach strategy using Facebook. Researchers found that people who used Facebook tended to check their Facebook page even when their phones were turned off. SSTAR will set up a FB account under a generic name. During the enrollment process, care coordinators will familiarize enrollees with the name and appearance of the FB account. Enrollees will also show their care coordinator what their own Facebook page looks like so we can be confident we message the correct FB account. If contact through traditional means becomes unsuccessful then a private message will be sent through FB messenger, asking that they contact their care coordinator. When this FB outreach was introduced seven years ago as part of a NIDA Clinical Trials Network (CTN) study, the research staff at SSTAR found that it worked very well. The people who agreed to let us use it would call within 30 minutes of receiving a private message.

Another approach that we plan on using is identifying unmet social needs among hard to reach enrollees. The care coordinators initial contact with enrollees will involve having them identify the economic and social factors that are preventing their engagement in care. By having a patient-centered conversation, rather than stressing aspects of compliance with a medical regimen, we think enrollees will have a more vested interest in talking with and engaging with the care manager.

Our affiliated partner HealthFirst Family Care Center will apply aspects of its Complex Care Management (CCM) model to engage enrollees in care. The CCM model delivers care management services to the enrollees' in their homes and offers support and assessments such as health education, disease management, and depression assessment during home visits.

Martha's Vineyard Community Services plans to engage youth and young adults (ages 18-26). Care coordinators from the MVCS Island Wide Youth Collaborative will provide the CP services for these individuals. The care coordinators will connect with enrollees at their residence, through the schools, or make the connection through their clinician. Private practice clinicians and schools will be pints of connection for those receiving care through our outpatient mental health clinic. For adults (ages 26 and above) recovery coaches will provide the care coordination and outreach will occur through their systems of care (DMH, DDS etc.). The recovery coach will connect with consumers at their residence, Daybreak Clubhouse, hospital emergency department, or wherever they are on the island.

1.b. Planned strategies for outreaching to and engaging with Assigned Enrollees with Substance Use Disorders

Mobility is a key strategy for the outreach and engagement of enrollees with substance use disorder. SSTAR plans to use two approaches that are aimed to "meet the client where they are". We will place a care coordinator at Fellowship's residential and supportive housing program and Steward Hospital to outreach to enrollees in need of support. In addition to these placements, care coordinators will routinely travel to local events and area businesses, shelters, and other places where enrollees may likely be. SSTAR will have outreach staff who work with law enforcement and homeless shelter staff to stay actively in touch with enrollees. By monitoring social media, care coordinators may be able to determine where an enrollee may be and if they are in need of outreach. SSTAR will use a University of Wisconsin phone app that works to link enrollees internally to a care manager, along with other key features that help with recovery, including a GPS location feature. SSTAR is currently researching other health and wellness apps and technologies (such as MyStrength) that allow for greater interaction and consistency in connecting with clients.

Fellowship Health Resources (FHR), one of our affiliated partners, will have care coordinators throughout the Cape involved in community outreach. Care coordinators will be working out of FHR's support housing and in the community with enrollees who are living independently. Their roles will be to ensure that the enrollees make it to their medical appointments and self-help meetings such as AA or NA. FHR has agreements with Cape hospitals, health centers, and recovery centers to conduct outreach at their facilities as well.

1.c. Planned process to obtain and document Assigned Enrollee's agreement to participate in CP Supports through a participation form

With the integration of behavioral health and medical health electronic records, the SSTAR has implemented signature pads for enrollees to sign enrollment agreements at the time of the initial visit. In addition, all enrollment questionnaires will document whether or not an enrollee has given verbal consent to participate in CP support. All enrollees will have signed

consent agreements either in a paper record or electronically stored in the EHR via signature pads, or transmitted/scanned in from other sources. Affiliated partners with an EHR will receive an alert to update the treatment plan and remind them when enrollment agreements are due. Other partners will establish a reminder system for updating treatment plans.

2. Comprehensive Assessment and Person-Centered Treatment Planning

2.a. Process for conducting Comprehensive Assessments

A comprehensive treatment planning process will begin at the initial visit and is completed in most cases by the third session. The comprehensive assessment will be completed by a clinician who will interview the enrollee and, if appropriate with proper releases, his/her family and/or support system to assess the enrollee's physical health; psychological, social, economic, educational, functional, and development statuses; vocational assets and disabilities; and a comprehensive drug and alcohol history. Throughout the process, enrollees' strengths, abilities, and needs will be identified. The comprehensive assessment will also capture information on services to be provided, frequency, the service goals described in behavioral terms with timelines, clearly defined staff and enrollee responsibilities, and assignments for implementing the plan.

SSTAR and its affiliated partners will try to obtain input for the comprehensive assessment from the enrollee's primary care provider. The care coordinator will ask the enrollee to sign a release of information in order to contact their primary care provider. The care coordinator will send a request to the primary care provider indicating that the enrollee has engaged in behavioral health services and requesting a copy of the latest physical, a description of past treatment procedures, past and current diagnoses or problems, and currently and recently used medications. If the enrollee does not have a primary care provider, the care coordinator will encourage them to establish a relationship with a primary care provider at SSTAR and with one of our health provider partners. The comprehensive assessment plan will be updated annually.

2.b. Process for conducting Person-Centered Treatment Plans

2.b.1. Planned processes for developing the Person-Centered Treatment Plan, including ensuring the Assigned Enrollee participates in the process

Usually the comprehensive assessment will be completed at the second visit, and the enrollee's treatment plan will be formulated based on their cited goals and objectives for their care. Each treatment plan is patient-centered and focused—the care coordinator will not dictate any goal. The care coordinator may include family members or other supportive individuals at the request of the enrollee in the development of treatment goals. The treatment plan will reflect identified problems, measurable goals of treatment, and anticipated length of treatment to accomplish goals. The enrollee and care coordinator will sign the treatment plan. The treatment plan will include at least the following information:

- The enrollee's strengths, skills, resources, and degree of family involvement

- Type of intervention(s)
- Preferences in terms of counselor, appointment time, and services
- Treatment goals with observable and measurable objects
- Time frames for accomplishing goals
- Enrollee's signature on the treatment plan indicating their involvement in its formulation
- The date the plan was last reviewed and/or revised
- Clearly defined responsibilities and assignments for enrollee and staff in implementing the plan.
- The signatures and licenses of the clinical supervisor reviewing and/or revising the treatment plan

2.b.2. Planned processes for documenting the Person-Centered Treatment Plan
SSTAR and all affiliated partners, including the materials subcontractor, have an EHR that will allow us to maintain the treatment plan in the electronic record.

2.b.3. Planned processes for updating the Person-Centered Treatment Plan
At a minimum, the care coordinators and enrollees will review treatment plans and goals every six months or sooner if there are major changes in health or achievement of goals/objectives. When goals/objectives are achieved or new ones are added, this will be reflected in the treatment plan.

2.b.4. Planned process for ensuring the Assigned Enrollee and the Assigned Enrollee's PCP or PCP Designee approve the Person-Centered Treatment Plan
Enrollees that have a PCP at SSTAR or at our community health partners' sites, the plan will be in the EHR or other health information system for them to review and approve. If an enrollee's PCP is outside of the organization, the care coordinator will work with the medical practice to get the plan approved if the enrollee has signed a release of information form. SSTAR will work with external PCP practices to explore electronic transmission options using secure data transmission resources.

3. Care Coordination and Care Management

3.a. Identifying stakeholders involved in an Enrollee's care
As part of the comprehensive assessment, enrollees will be asked to provide the names and contact information for all health and social service providers, state agencies, and others involved in their care. The care coordinators will first contact these stakeholders by phone to inform them of our involvement with the enrollee. If care coordinators are unable to reach them by phone, then written communication will be sent out either by email or regular mail.

3.b. Exchanging information with such stakeholders
Upon initial contact, enrollees will be asked to sign a release of information form for their primary care provider and other support service agencies in order to obtain medical and service records. SSTAR has a number of approaches for exchanging information with providers to facilitate enrollees' care coordination. The method of transmission will depend on the capabilities of the provider in question; however, SSTAR is capable of both sending

and receiving electronic information via interfaces with NextGen Share, FTP, Mass HIway, encrypted email files, etc. As an ONC certified system, NextGen conforms to the HL7 standards for transferring clinical and administrative data between applications so, for all providers who are also on an ONC certified system, SSTAR will be able to transmit information back and forth electronically through the transmission of CCDAs. SSTAR is working with its affiliated partners to explore setting up more robust interfaces to support the regular transmission of information that is expected to be required in supporting this contract. SSTAR also has relationships with local hospitals and is pursuing expanding its capabilities to receive more information from them in an electronic format to better facilitate rapid awareness of enrollee hospitalization.

3.c. Identifying and organizing members of the Enrollee's care team

All enrollees participating in the CP program will have a care coordinator as a member of their team. Other medical and service providers that will be part of the team will depend on the enrollee's request that such a provider is included on the care team or if the provider is able to be part of the care team. SSTAR and affiliated partners with medical staff will not have much difficulty involving medical providers as part of the team. For those that are more social service-based, it may be difficult to formally include a medical provider on the care team. In these cases, we will request input for care coordination as appropriate or requested by the enrollee.

3.d. Ensuring effective ongoing communication across all stakeholders, including exchanging essential documentation

SSTAR and its Community Partners will make every attempt to include enrollees' PCP, outside agency providers, in the care coordination activities for the enrollee. When an enrollee has issues related to medical care, input from a PCP will be sought. For other service providers that are outside of the organization, we will invite them to care planning meetings and/or have them participate through teleconference or email communication.

4. Care Transitions

An enrollee may transition out of the CP program for the following reasons:

- ***The treatment plan goals have been successfully achieved and no further care coordination intervention is warranted.***
- ***The treatment plan goals have been successfully achieved, and although other issues have been identified, the enrollee is not willing or able to continue treatment on the other identified issues at this time. In this event the enrollee will be provided information on how to access CP services if they want to reenter into care.***
- ***The client expressed the desire to not continue with the care coordinator and/or behavioral health team, in which case the enrollee will be referred by the care coordinator to another team within the organization or to another CP.***

In all care transitions that involve the enrollee accessing services with another organization, SSTAR and its affiliated partners will assist the enrollee in identifying a new service provider and arrange meetings with the new provider to introduce the enrollee. Care

coordination services, such as arranging for transportation to the site or visiting the site with the enrollee, will be offered. All records that are required for a smooth transition of services will be shared with the new provider after the enrollee signs a release of information form.

5. Medication Reconciliation

Care Coordinators will obtain a complete and accurate list of each enrollee's current medications (including Name, Dosage, Frequency, and Route). Medications will be verified in several ways.

- Enrollees may bring medications in an up-to-date container. The medication should match the description on the bottle. If the medication is out of date, care coordinators should inquire why and, if the enrollee wants to restart it, contact a medical provider.
- Care coordinators will call the prescriber's office if the enrollee has an outside PCP.
- A call to a pharmacy may be placed to confirm medication dosage, frequency, etc.

Reconciliation will be done minimally at admission to the CP program, discharge, and whenever medications are changed. All medication information will be entered into an electronic medical record or paper medical record.

6. Health and Wellness Coaching

6.a. Health and wellness education, coaching and health promotion programs

Through several programs, including our SAMHSA health integration project and MBHP Practice-Based Care Management program (PBCM), all patients are sent mailings, as well as local flyers inviting them to a variety of wellness activities. On a weekly basis, SSTAR offers over 10 wellness groups on a variety of topics such meditation, healthy cooking, medical screenings, and walking programs to more social activities like painting for relaxation, journaling and mindfulness techniques. Enrollees will be able to participate in these programs at SSTAR and at affiliated partner sites that offer health and wellness classes. In instances where our partner organizations do not offer these activities, the care coordinators will be able to link enrollees through referral to community resources such as the YMCA.

6.b. Methods for ensuring the Engaged Enrollee's goals for the health and wellness programs are recorded and tracked

During treatment planning, enrollees will be asked to identify at least one health and wellness goal. Depending on the goal that the enrollee is working on, we will research and access free mobile apps that can be used to help them stay engaged. In addition, SSTAR will use text-messaging software that care coordinators can use to send reminders and messages of encouragement to enable enrollees to meet their goals. The information on the health and wellness goals and progress will be kept in the EHR.

7. Connection to Community and Social Services

7.a. Plans to evaluate Engaged Enrollees for social service needs
Enrollees' social service needs are evaluated during the initial interview, which will include an HRQOL (Health-Related Quality of Life) measuring healthy days, along with questions that focus on barriers to care. The utilization of an assessment tool will facilitate clear identification of social needs rather than direct questions or confrontation about medical or behavioral needs. These measures focus on the impact that the health or behavioral health status has on quality of life, as well as assess for positive, supportive factors.

7.b. Ensuring Care Coordinators are familiar with a wide breadth of social services and supports, and providers of these supports
As part of the CP's planned meetings, care coordinators will meet regularly to review member activities and discuss/share information about various services at their agency and in the community. This process will ensure that all care managers are knowledgeable about available resources in the community. In addition to these meetings, all care coordinators will have access to online support tools and services that allow for on-demand learning and communication. Care coordinators will have access to Office365, available on their phones and computers to share resource information, ideas for a new program, etc.

7.c. Planned strategies for collaborating with ACOs to recommend Flexible Services on behalf of Engaged Enrollees, and following-up on the outcomes of such supports.
Care coordinators will be in regular contact with the enrollee's ACO in terms of overall care management and, when indicated, Flexible Services. The care coordinators will recommend Flexible Services based on information gathered in the comprehensive assessment, care planning, and care coordination processes. Recommendations such as air conditioners for asthmatic children, housing support for enrollees with unstable housing, etc. will be common as part of the care coordination process. Flexible Services will be an agenda topic at each quarterly CP meeting so that staff carrying out CP activities across SSTAR and all affiliated partners and the material subcontractor will have a high level of knowledge of available Flexible Services they can recommend. While it will be the ACO's responsibility and decision to approve recommended Flexible Services, the care coordinators will be responsible to follow-up on any approved Flexible Services. This includes working with the patient to ensure they receive the approved services, helping to remove any barriers to receiving the services, and tracking the outcomes and reporting back to the ACO once the services have been received.

D. Innovative technologies for service delivery
SSTAR's Community Support program and Recovery Coach services rely on cell phones and text messaging to maintain contact with the clients on their caseloads, and we expect all the care coordinators will adopt these tools. Mobile phone apps have also been incorporated in various services at SSTAR. SSTAR was a founding member of the ACHESS research consortium that evaluated the effectiveness of a mobile phone app to support recovery. Patients at SSTAR's Methadone Maintenance program are now using this app, and we expect to be able to offer its use to enrollees through the BH CP. Among the popular features of this app is the group chat with other recovering clients, a daily check-in questionnaire that

produces a graph representing recovery risk and resilience levels over time, and feedback to care coordinators alerting them of a need for help.

Telehealth strategies are currently used to link an off-site psychiatrist to the daily team meeting on SSTAR's dual diagnosis unit. We're using a HIPAA-compliant video conferencing platform, a large TV monitor in the team room with the psychiatrist participating remotely, and the client record from our electronic health record displayed as well. Care coordinators and enrollees in geographically distant locations may be offered consultation to care coordination and/or care conferencing via this technology. SSTAR's classroom has a large interactive whiteboard that works well with video and audio conferencing. Through these tools, remote access to governance, the advisory board, and other meetings will be an option for those who cannot attend in person.

Care coordinators will have tablets linked to the project's EHR/Care Coordination software for both inquiries and entry of service notes. When services are provided in the community, enrollees will be able to sign treatment plans and other documents digitally via the tablets.

E. Personnel and staffing

1. An organizational chart of CP program staff

Please see attached organizational chart.

2. A sample staffing model for the number of Engaged Enrollees in each Service Area

Table 4: Estimated Number of Enrollees by Service Area

Service Area	Estimated Number of Enrollees	Agency Responsible for Care Coordination	Care Coordination FTEs	RN FTEs
Fall River	2500	SSTAR, HealthFirst, Fellowship Health Resources	50	10
New Bedford	900	Greater New Bedford Community Health Center & Fellowship Health Resources	18	3.6
Barnstable	500	Fellowship Health Resources	10	2
Orleans	425	Fellowship Health Resources	8.5	1.7
Falmouth	250	Fellowship Health Resources	5	1
Taunton	250	SSTAR	5	1
Attleboro	200	SSTAR	4	.8

Wareham	150	Greater New Bedford Community Health Center	3	.6
Oak Bluffs	100	Martha's Vineyard Community Services & Fellowship	2	.4

3. Recruitment plans including timelines to recruit staff for any personnel positions not currently filled, and job descriptions and qualifications for each personnel position.
SSTAR and its affiliated partners plan to reallocate time of some current employees providing care management and related services under other programs such as Recovery Coach and CSP to the BH CP. Each partner has some nursing care management staff a portion of whose time could be reallocated as well. Beginning in Spring, we and our partners will begin recruitment of additional staff . Staff recruitment will be an ongoing effort as caseloads increase.

4. Recruitment and hiring of staff from the cultural and linguistic communities
SSTAR will make every effort to recruit and retain staff that mirror our population of focus. We will work with local organizations and community groups to identify qualified individuals that have the cultural competency and language skills to serve our population. As we recruit for care coordinators, we will advertise in local media and job search sites. In our job descriptions, bilingual/bicultural personnel will be clearly stated.

5. Proposed training, orientation plans and modules for staff
SSTAR will provide training for all our care coordinators and those of our affiliated partners and subcontractor at initial hire and annually. This training will consist of basic information about mental illness and substance abuse, health and wellness principles, trauma informed care, client-centered assessment/treatment planning, monitoring, and follow-up. Overdose prevention training will be included for all staff. Staff not proficient in using Motivational Interviewing and Family Systems will be afforded additional training in these modalities. Likewise, staff that have not been trained in SBIRT will be trained. For SBIRT training, we will conduct annual SBIRT trainings and professional development for all care coordinators. Staff will have access to an online learning platform, Relias, which, in addition to required trainings related to all disciplines employed, is also customized to include agency-specific trainings and competency exams. SSTAR's EHR trainer is adept at creating online courses for staff that are job and site specific. In so doing, she can create training programs that review social services and supports with required competency tests at the completion of each module. Since the system is available to staff 24/7 and is self-paced, all staff can complete trainings at times that are most convenient to them. In addition to the topics outlined above, we plan to conduct focused training on the following curriculums, models, and standards.

Training for cultural competency: Targeted to all care coordinators, training will focus on sensitivity to the cultural context in which referral, assessment, and treatment occur; recognition of individuals cultural backgrounds, belief systems, the role of spiritual practice; traditional remedies in both assessing the problem and in designing and carrying out

interventions; understanding DSM-V culture-bound syndromes; and effective treatment regimens in minority populations.

Recovery Support Navigator program: SSTAR will utilize an existing curriculum based on the SAMHSA Recovery Support Imitative (SAMHSA Financing Center of Excellence). Training will include substance abuse care, motivational interviewing, and group coaching. The Brief Negotiated Interview and Active Referral to Treatment (BNI-ART) Institute, a program of Boston University's School of Public Health, will provide training. The BNI was originally developed for use in the emergency departments and has been reviewed in several studies demonstrating lasting, positive changes in health behavior. It is a patient-centered intervention and intended to be brief.

Case Management Society of America (CMSA): SSTAR will include Standards of Practice and Care for Case Management in its training for care coordinators. The standards outline knowledge, skills, and competencies for professional care managers with a focus on collaborative care coordination. It was developed by nurses and provides a thorough approach and understanding of how care management should work.

Nonviolent Crisis Intervention (NVCI): All care coordinators will participate in training for staff that may conduct home visits to enrollees' homes. SSTAR has an NVCI-certified staff that can train care coordinators. Our staff is trained in and uses the program designed by the Crisis Prevention Institute (CPI). CPI was established in 1980 to train staff to use respectful, noninvasive methods for managing disruptive and assaultive behavior.

ARISE: A family engagement model that uses an invitational approach to help family members help individuals with substance abuse disorder seek treatment. SSTAR has on staff certified ARISE interventionists who are certified supervisors and provider/interventionists. Our staff have been trained by the founder of ARISE, Dr. Judith Landau, who has spent over 50 years developing, implementing, and training providers in this model. Research studies have demonstrated the effectiveness of ARISE in that 83% of individuals entered into treatment as a result of family intervention.

6. Description of staff retention strategy

SSTAR has a robust retention strategy in order to attract the most qualified staff. We offer a competitive salary and benefits package and generous earned leave time. Our health benefits include dental and vision, and a 403b retirement plan is also offered to all employees. When possible, tuition assistance and training/education opportunities are afforded to staff. SSTAR also participates in the National Health Service Corp loan repayment program for all licensed providers. We work with staff to manage work/life balance and to further their education by providing flexible scheduling and support. Currently medical doctors receive $3,000 for continuing medical education, and other licensed clinicians receive $2,000 in continuing education annually. We also pay for all health providers' licensure and certifications.

F. Implementation Plan and Timeline

Please refer to attached monthly and quarterly implementation plans.

G. Budget Report and Budget Narrative

Please refer to Attachments B and C for Budget Report and Budget Narrative.

H. Sustainability

DSRIP funds will be used to purchase software, consultation, and hardware to facilitate electronic communication among the sites that relate to care coordination functions, data collection and analysis, etc. These funds will also be used to offset initial staff recruitment costs, training and staff wages during the start-up period. Once the BH CP services are fully operational, the staff costs will be sustained by service-related revenue. As much as possible SSTAR will try to reduce cost by using models such as training the trainer for new care coordinators and e-learning tools such as Relias for professional development requirements. The IT and related expenses are primarily one-time start-up costs. Maintenance of these systems represent a level of expense that would be sustainable through each partner's general operating revenue including the BH CP service-related fees. Other income sources such as shared savings/quality performance bonuses through the ACOs is another means by which the infrastructure and capacity building projects implemented will be sustained.

I. Quality Management and Performance Monitoring

1. A description of the Bidder's quality improvement program

SSTAR's agency-wide Q/I Committee is made up of a selected group of staff members who are responsible for collecting and reviewing data on performance-based activities in clinical and program areas. We perform reviews of regulatory compliance and compliance with clinical standards and identify areas where corrective measures are needed. Periodically, we administer patient satisfaction surveys by program to help identify issues coming out of a patient's experience. Our organization also does chart/record audits conducted by clinical teams of program managers on a periodic basis throughout the year. Upon completion, results are discussed with program managers in order to address identified issues.

For the CP program, SSTAR in collaboration with its Affiliated Partners will establish a quality management/quality improvement committee within three months of the planning phase. Each partner will assign a representative to participate on the CP QA/QI committee, and a chair of this committee will be selected among the representatives. Members of the committee will develop a plan annually on a selected area of care such as chronic disease management, care transitions, care management, etc. The annual QI plan to be developed by the committee will include goals and measurable objectives for the selected area of care and a timeline for meeting objectives. Similar to our current QI Committee, the CP's committee will use PDSA Cycles: Plan-Do-Study-Act. The PDSA Rapid Cycle will allow us to identify areas

for improvement, implement interventions, and measure changes over periods of three months rather than the standard eight to twelve months. As the lead organization, SSTAR will ensure that data reporting for quality measures are gathered and stored in a central database that can be accessed by our partners for data sharing. The committee will establish that the frequency of data is collected to allow enough time for data review and analysis prior to the annual submission to EOHHS.

2. Quality initiative for Budget Period 1, including measures for success
*Quality Improvement Area***:** Care Coordination and Care Management
Care coordinators will complete a comprehensive assessment for each enrollee who signs a participation form.

Evaluation Method: The clinical manager will review EHRs of enrollees for completed comprehensive assessments.

Measure of Success Goal: 80% of enrollees with a signed participation form will have a completed comprehensive assessment.

3. The functions of the Bidder's quality committee, including the composition and reporting structure within the Bidder's organization.
SSTAR's organization-wide Medical Quality Improvement Committee (Q/I) utilizes a total quality management approach. It is multidisciplinary and members include senior managers and health center staff, who are encouraged to participate in a systematic approach to planning and implementing a continuous organizational improvement process. Its approach is focused on satisfying customers' expectations, identifying problems, building commitment, and promoting open discussion among workers. We use PDSA Cycles: Plan-Do-Study-Act as our process. This method allows for rapid cycle testing on a continuous basis. Quality indicators are monitored and reported monthly. CP program indicators will be added to the Q/I committee, and a member of SSTAR's CP staff will participate on the committee. The Q/I Committee addresses critical issues and monitors compliances to identify potential problems, which could impact client care and staff performance and ensure that corrective action has been instituted and quality of care is improved. The Q/I Committee identifies ways to improve and standardize internal communication, implement client and staff satisfaction surveys and improvement processes, and streamline programmatic data collection to measure success. The Medical QI committee submits quarterly reports to the Board of Directors.

J. Coordination with ACOs and MCOs

1. Communicate skills, expertise, and value to potential ACOs and MCOs

SSTAR has a 40-year history in Massachusetts, and our programs are well-known to the Accountable Care Organizations (ACO) and Managed Care Organizations (MCO) in the service areas selected for this project. As an integrated primary/behavioral health organization, we were chosen by the ACOs in our area to become part of their primary care network. We have now met with three of the ACO's in our service area (Boston Medical Center, Southcoast Hospital Group, and Steward Health Care Systems) to discuss our interest in providing care management services. We have also met with the Beacon MCO, which will

be providing managed behavioral healthcare for both BMC Health Care and for Southcoast ACO. We have agreed to work with Beacon MCO in order to provide the best quality care for our clients. For the past three years, SSTAR has been working with Beacon's subsidiary MBHP on a pilot care management for its highest utilizers. The project has produced meaningful outcomes and was extended by Beacon beyond its initial pilot phase.

SSTAR has a long history of collaboration with the two largest ACOs in Fall River—Southcoast Hospital Group and Steward Health Care Systems—and will be able to build on these existing relationships to collaborate on new care management services. Similarly, SSTAR has a long-standing history of collaborating with many MCOs in the state including MBHP, Beacon, and Blue Cross/Blue Shield Foundation on demonstration projects and grants. SSTAR's experience in implementing projects collaboratively with ACOs/MCOs is a powerful marketing tool. Our knowledge of their organizational structures provides the necessary skill sets to craft a successful marketing strategy. For example, knowing the roles of medical directors, clinical practice committees, etc. in these organizations will help us more accurately and successfully market our services. We also know that a marketing strategy that is education-based rather than sales-based will increase the likelihood of success in collaborating with ACOs/MCOs. SSTAR is well positioned to market to and communicate with local ACOs, and our experience offers a valuable option for these entities when selecting organizations that can best meet their needs and that of their enrollees.

2. Branding and marketing plans to ACOs and MCOs

SSTAR's marketing strategy will be to develop collateral materials such as brochures, newsletters, etc. that highlight our reputation as an integrated behavioral health care organization that uses a whole-person approach to care delivery. As one of the first agencies to integrate care at the start of the HIV epidemic, SSTAR has built a reputation as a holistic/multi-service provider. With nearly 40 years in the field of integrated care and addiction treatment, SSTAR has developed many significant relationships with area ACO's and MCO's and has direct contact with their decision-makers. Our marketing plan will be to highlight our decade-long relationships with ACOs and MCOs and showcase our care delivery approaches that are grounded in innovative research, evidence-based practices, and professional educational training. We plan to hold workshops and seminars on these research findings and practices for ACOs and MCOs, as well as for other area providers. In addition to live events, we plan to use our local media and social media platforms, such as Facebook and Twitter, to bring greater awareness to our services.

3. Strategy to engage and collaborate with multiple ACOs and MCOs in the proposed Services Areas

SSTAR has already established relationships with many of the ACOs and MCOs including Beacon, MBHP, NHP, and others. We will continue to engage and collaborate with all ACOs and MCOs in our area. Our plan is to have an open line of communication with these organizations by holding frequent meetings to discuss and develop procedures, protocols, and responsibilities for the new CP program. SSTAR is also planning on developing training and educational sessions that will be beneficial to the CP/ACO/ MCO partnerships.

4. Strategy for conflict resolution with an MCO or ACO

Conflict often arises simply due to a lack of clear and consistent communication. SSTAR will strive to keep all lines of communication open and provide clear lines of communication so that both organizations' staffs will know the proper channels to discuss potential issues. We are planning to use a variety of communication channels such as telephone conferences, emails, and face-to-face meetings. In the event that one form of communication breaks down, we will try other means to resolve any misunderstandings. For example, should verbal communication not clarify an issue, SSTAR will encourage written communication. Written communication may provide a more effective way to clarify issues, and it offers a means of documenting issues that can be referred to at a later date. If a conflictual situation arises in working with an MCO or ACO where both organizations cannot reach an agreement, then the assistance of a third party mediator will be used to reach a mutually agreed upon solution.

Section 7.5 Initial DSRIP Participation Plan

A. Executive Summary

1. Goals, Challenges, and Proposed Solutions

Goals. Our strategic business plan affirms our commitment to EOHHS' goals for the LTSS Community Partners(CP) program over the next five years.

EOHHS' Goal	CCHP/LTSS Approach
Improve the Enrollee experience and quality of care for Enrollees with LTSS needs	• Invest in initiatives to increase Enrollee awareness of available services and supports such as education that targets increasing understanding of health care needs and services • Promote Enrollee access to services
Create opportunities for ACOs and MCOs to leverage the expertise and capabilities of existing CBOs	• Work with our partners to implement consistent practices across our programs that support LTSS services to manage high-risk populations including Transitional Care Management • Invest in new technology and workforce
Improve collaboration across ACOs, MCOs, CPs, and CBOs to address social determinants of health through collaborative efforts	• Prioritize expansion of community linkages with ACO Plans, medical and behavioral health providers, other community partners, and social service providers • Invest in and support initiatives that promote a shift from institutional care towards community-based LTSS as well as our community-based primary and preventative care • Collaborate/partner with programs that address Enrollees' social service needs and establish linkages with social service organizations
Support Enrollees with complex LTSS needs and help them to navigate the system	• Develop educational materials and opportunities (community forums, classes) to inform Enrollees and families of available services and supports • Implement consistent processes across organizations to coordinate care

Opportunities and Proposed Solutions. The MassHealth LTSS CP program requirements create both opportunities and challenges for our collective organizations. Our success as an LTSS CP will be defined by our ability to re-define ourselves, including our capacity to integrate LTSS and Behavioral Health (BH) services for the highest-risk MassHealth Enrollees within our Central Community Health Partnership LTSS (CCHP/LTSS) and CCHP BH organizations. We also see challenges and opportunities in partnering with ACOs, State agencies, medical and BH providers, ancillary service providers, and Community-based Organizations (CBOs) to coordinate care to meet Enrollee needs in the least restrictive setting of the Enrollee's choice.

CCHP/LTSS recognizes an opportunity to design and implement an integrated care model that has the potential for better, sustainable outcomes at a lower cost to the State. We have the opportunity to integrate BH and LTSS services for Enrollees we already serve within our organizations. Maintaining this level of continuity and trust is ideal for the Enrollees we serve as they can receive the full array of services in one location through a trusted source of care.

The CCHP/LTSS timeline calls for a rapid pace of implementation to conduct complex work. CCHP brings a major advantage, given our existing strong relationships with ACO Contractors and their Partners in our geographic catchment area.

CCHP/LTSS recognizes the importance of sharing assessments and care plans across the full provider continuum and of conducting reporting activities. We will work closely and collaboratively with the State and ACOs to develop efficient technology solutions that bring the various stakeholders together rather than developing independent systems that do not speak to one another.

2. Number of Assigned and Engaged Enrollees

CCHP/LTSS intends to support approximately1,000 Engaged Enrollees under the Contract by the end of Budget Year 1 and grow to support over 1,700 Engaged Enrollees in Budget Year 5.

3. Service Areas

CCHP/LTSS is bidding to provide LTSS CP services in most of the service areas within the Central Region. The same group of organizational partners (identified as CCHP/BH for which The Bridge is the Lead Agency) are also bidding to provide BH CP services the same service areas. See Section 7.2.A. Attachment D.

4. Plans to Operationalize the LTSS CP program

Implementing the Plan. During 2017-2018, CCHP/LTSS will implement the LTSS CP start-up requirements to deliver the required services and supports on Day 1 of Contract start. We will conduct significant contracting efforts that establish key organizational and governance structures and roles, define significant contractual relationships with our network providers and ACOs, build operational functions, work flows, policies and procedures and prepare for the Readiness Review. Once the Contract is operational and basic requirements are met, CCHP/LTSS will enhance and improve our competencies, including our capacity to serve more Enrollees; the breadth and depth of our relationships with ACOs, and CBOs; and our IT capacity. Together, our work will evolve over time in a manner that enhances the Enrollee experience and improves their health outcomes.

A summary of our five-year plan follows.

B. Supporting Populations and Community Engagement

1. Connections to the Community and Community Members

Existing Community Partnerships	
Organization	**Description**
Community-Based Organizations (CBOs)	Our LTSS CP has a history of developing strong community connections. We actively engage with CBOs in our Service Area including, but not limited to the United Way organizations in each of our Service Areas, Archway, Youth Connect, City of Worcester DPH, Coalition for a Health Greater Worcester, the Spanish American Center, CENTRO, the YWCA, Worcester Community Action Council, Community HealthLink and other Federally Qualified Health Centers. We will build on these existing relationships to develop and sustain connections to CBOs and augment our portfolio of services and competencies.
Advocacy Groups	We collaborate with organizations such as The Arc of Massachusetts, Association of Developmental Disabilities Providers, the Brain Injury Association of MA and Mass Advocates Standing Strong.
Behavioral Health Providers	We work closely with community-based BH providers to coordinate care by referring Enrollees to providers including: Community Healthlink, Riverside Community Care, CHL Lipton Center, UMass Memorial and affiliates, Heywood Hospital, The Griswald Center, The Wells Center, Harrington Hospital, South Bay Intervention, Justice Resource Center, Advocates, Inc., South Middlesex Opportunity Council, Clinical and Support Options and Center for Human Development, among others.
Housing/Shelter Providers	We work closely with the City of Worcester's Executive Office of Economic Development, Office of Housing Development, on a program funded through an Emergency Solutions Grant to provide support for homeless individuals who have mental health and substance use challenges. We serve on the Worcester County Continuum of Care Committee and partner with the Central Massachusetts Housing Alliance and others to address homelessness in the area. Additionally, we partner with organizations such as Central MA Housing Alliance (homelessness continuum of care) and various housing agencies to link Enrollees to housing services.
Social Service Organizations	We have close relationships with social services organizations including Worcester Community Action Council, Employment Options, and Genesis Clubhouses. We also directly refer Enrollees to agencies such as: Montachusett Opportunity Council (child care, education, workforce development, nutrition, health, community services, asset development, energy conservation and housing and homelessness services), Our Father's House, Gardner Community Action Committee, The Hoyt Foundation, Friendly House, and Daybreak for emergency housing; South Middlesex Opportunity Council; and, Central MA Housing Alliance.
State Agencies	We maintain contracts and long-standing relationships with MassHealth, Department of Public Health, Department of Developmental Services, Department of Mental Health, DPH-Bureau of Substance Abuse Services, Department of Children and Families, Massachusetts Rehabilitation Commission, local Health Departments, and others.

Participation in Community Health Needs Assessments: We participated in the Central MA Regional Public Health Alliance, which has enabled us to develop relationships with CBOs and gain an understanding of Service Area needs.

Examples of successful community connections: Alternatives successfully links individuals served with local community organizations by training its staff as 'community connectors,' mapping the community resources available in each locality, and matching individuals' preferences with available organizations. Examples include: matching aspiring actors with community theater groups; music lovers with community concert bands; volunteers with churches that host community suppers; and book lovers with local book clubs. We will apply the lessons learned to other collaborative community connections and continue to expand our relationships within the communities we serve while combatting pervasive social isolation.

Link to Business Plan: CCHP/LTSS sees multiple opportunities to link our community connections and our business plan. We seek to increase sharing of information using IT connectivity with ACOs and MCOs. One prospective ACO has committed to including CCHP/LTSS in a secure text and email-based system to alert the appropriate Care Coordinator if an Enrollee is hospitalized at one of four community hospitals. Going forward, we will enhance overall connectivity with CBOs beginning in year two.

2. How We Will Grow Community Connections

CCHP/LTSS will continue to assess Enrollee needs and community services and develop creative solutions to grow those connections. We will also enhance our ability to identify and address social determinants of health such as housing, food, and safety, breaking down existing silos and improving care integration.

3. Maintaining Information on Providers and Community Resources

We will systematically update information regarding community organizations as changes occur and, as we add organizational relationships to serve Enrollees within:

A Community resource guide: We will develop and maintain a community resource guide as a reference for staff in both hard copy and electronic formats.

Staff training: CCHP/LTSS will organize and conduct on-going educational sessions for staff during work hours, including community resource information and updates during new staff orientation, staff conferences, invited guest speakers from community organizations, and participation in community events.

Care Team meetings: The Care Team will review community resources included in each Enrollee's Patient-Centered Treatment Plan and will consider services and relationships with additional community organizations. We will review available options with Enrollees during Care Team meetings and educate the team regarding available services and supports.

Website updates/newsletters: CCHP/LTSS will develop and issue electronic information updates to ACOS, MCOs, CBOs and other stakeholders regarding key developments within CCHP/LTSS.

C. Community Partner Supports and Activities

1. Outreach

a. Locating and Engaging with Assigned Enrollees with Complex LTSS Needs

We will employ all available resources to locate and engage Assigned Enrollees who have not otherwise been engaged in services. As we do today, our approach will begin with understanding the Enrollee's needs, as they define them. We will seek to meet their basic needs by building rapport and trust and connect Enrollees to services without making them feel uncomfortable, judged or threatened. Our key outreach strategies, which are in place today, include:

CCHP meets the Enrollee at any available location in the community where they are personally comfortable and that the Enrollee selects. This includes their home, neighborhood locations, tent cities, motels, shelters, or congregate meal sites among other locales. We connect with the Enrollee and build trust, regardless of where we physically meet. During all contacts, we respect Enrollees and their families and seek to create an open, safe, friendly environment.

We will continue to hire highly qualified, skilled individuals who are trained in motivational coaching and understand cultural and linguistic needs. CCHP/LTSS staff are skilled at interacting with Enrollees with intellectual impairments, complex medical conditions and poor behavioral self-control and, are experienced at serving individuals on the autism spectrum. We will continue to hire staff with demonstrated skill and experience serving Enrollees with complex needs and that understand cultural, linguistic and other needs.

Engagement Process. CCHP/LTSS will employ Bachelor's level LTSS CP Care Coordinators to perform outreach, assessment, care planning and care management tasks for Assigned and other potential Enrollees. CCHP/LTSS will make at least three attempts, including at least one attempt to contact the Assigned Enrollee face-to-face, unless the Assigned Enrollee wants to meet telephonically.

CCHP staff will obtain a participation agreement to confirm that the Assigned Enrollee wishes to participate in the delivery of LTSS CP services and will assign a Care Coordinator within five business days of receiving the signed participation form.

The initial LTSS visit will occur within three months of the Enrollee's assignment to CCHP/LTSS. Using motivational interviewing techniques, our Care Coordinator will explain how this initiative can help the Enrollee achieve their goals. CCHP/LTSS Care Coordinators will explain that the program is intended to help Enrollees overcome barriers to care; build a support network; and introduce ways to participate in community activities to improve their well-being. We will also explain the anticipated frequency and type of interaction available for CP service delivery.

If appropriate, CCHP/LTSS will make the first in-person contact during an acute care event at a local hospital, taking care to ensure that the Enrollee is comfortable. In this manner, CCHP/LTSS partners will proactively participate in the Enrollee's transition of care at the outset of their enrollment. Our Care Coordinator will explain that the Enrollee can opt out of receiving CP services at any time. Enrollees will also be able to request assignment to a different staff

member within our organization or assignment to a different EOHHS-designated LTSS CP at any point in time. We will further provide information on how to access the LTSS CP organizations' website and Consumer Advisory Board or an LTSS CP. Individuals who choose not to enroll will be provided with contact information should they choose to enroll later, and will be asked if periodic outreach from an advocate is acceptable.

Staff will provide individuals that choose to receive LTSS CP services information regarding the benefits, design, and purpose of LTSS CP supports. This information will be offered in written and verbal formats and will be available to Enrollees' in their primary preferred language for the most commonly spoken languages among the population served. Information regarding the LTSS CP service delivery process will focus on helping the Enrollee understand how to engage with their Care Coordinator. For example, we will provide Enrollees with detailed information regarding how to reach their LTSS Care Coordinator.

At the initial meeting, CCHP/LTSS staff will assess the Enrollee's needs in their primary preferred language with attention to cultural beliefs, building upon the ACO's Comprehensive Assessment. When a CCHP/LTSS Care Coordinator meets with the Enrollee, our staff will confirm the Enrollee's needs, as they define them, and provide support to help the Enrollee understand their LTSS options. CCHP/LTSS staff will develop an LTSS Care Plan under the direction of the Enrollee or their representative, if appropriate. The Care Plan will be based on the Comprehensive Assessment and conversations with the Enrollee and the Care Team. Where possible and desired by the Enrollee, the Care Coordinator who performs the initial contact with the Enrollee will serve as the LTSS CP Care Coordinator on an ongoing basis and will take a leadership role in delivering LTSS services as part of the Care Team.

If the Enrollee has both LTSS and BH CP needs, the BH CP Care Coordinator will serve as the primary contact. Within CCHP/LTSS, the BH CP coordination staff have the distinct advantage of being dually trained and can reach out to an LTSS Care Coordinators within the organization at any point in time, especially for Enrollees who are seen by CCHP/LTSS providers for both BH and LTSS services. This is the major reason that CCHP is applying to provide both BH and LTSS CP services; our qualifications to provide both sets of services afford an ideal level of coordination and convenience for Enrollees.

2. LTSS Care Planning

a. Ensuring Enrollee Meaningful Participation in Care Planning

We will place the Enrollee at the center of their Care Plan development and support them in communicating their goals, needs, and preferences to their Care Coordinator. We will include the Enrollee and their family at every step of the process. Our goal is to fully involve each Enrollee and, if appropriate, their family member, informal caregiver or guardian where applicable in developing and managing the LTSS Care Plan.

As part of the care planning process, we will identify and document person-centered goals and objectives and help the Enrollee meet their needs. We will listen to Enrollee feedback, document their needs in the Care Plan and continually reinforce their choices and preferences among care professionals on the Care Team.

b. Providing Informed Choice

Options Counseling is a cornerstone of the work that all CCHP/LTSS organizations provide. As such, providing informed choice will be a key aspect of our work with Assigned Enrollees.

CCHP/LTSS will ensure that the Enrollee and their family/caregiver have a full understanding of the benefits and services available to meet their needs, as they define such needs. Throughout the care planning process, staff will educate Enrollees on available resources, tools, and treatments, and encourage the Enrollee to make informed choices about their care.

We will train staff to provide unbiased information about LTSS to help the Enrollee take their next steps while ensuring he/she maintains control over the process. Based on the Enrollee's opinion, we may refer them to a regional Aging and Disability Resources Consortia (ARDC) for choices counseling. We will work in concert with CBOs to provide Enrollees with efficient access to LTSS.

3. Care Team Participation

a. Promoting Integration of LTSS Communication

CCHP is aware that the success of the LTSS CP program relies on our ability to coordinate care and information with ACOs and their provider networks that serve our Enrollees. We will develop and strengthen, on an ongoing basis, relationships with ACOs, MCOs and providers across the full continuum. Today, we advocate for the population we serve to help them consider their options and articulate their needs as a leader on their own Care Team in collaboration with the CCHP/LTSS Care Coordinator.

We are already working with ACOs in our geographic catchment area to develop the technology and processes that will allow the LTSS CP to participate on the Enrollee's Care Team during initial Team meetings, throughout the care planning process and at transitions of care. We believe that as medical and BH providers observe firsthand the expertise that we offer, our relationships will evolve and grow stronger, thereby allowing us to serve Enrollees better.

We are aware that Enrollees are best served by sharing complete, up-to-date information about their needs in a comprehensive Care Plan. Going forward, we aspire to share information across the ACO, the Enrollee's PCP, the BH CP if appropriate, State agencies and CBOs which are involved in the Enrollee's care delivery. Given this important need, CCHP/LTSS will seek to promote integration through our Information Technology (IT) strategy, described in **RFR Section 7.4** of this RFR submission. At the outset, we will a have a compliant, functioning IT solution; and, over time, we will participate in the development of an interoperable system that will enable us to share assessments, care plans, reporting and quality management functions.

b. Providing LTSS Expertise on Care Teams

We will connect each Enrollee to the services they need through collaboration with medical, BH and social service providers. As part of our ongoing processes, we will educate service providers on the unique needs of Enrollees with LTSS needs, LTSS services and supports, eligibility criteria, and how to access available benefits. We will do this as part of the care planning process, during routine communications, and when we work with specific providers to address Enrollee needs.

CCHP/LTSS's coordination and collaboration processes are in place among our participating organizations today. CCHP/LTSS already provides direct services to hundreds of qualified LTSS Enrollees and has developed significant expertise in involving key stakeholders on the Enrollee's Care Team to jointly plan and coordinate the delivery of quality services on behalf of the Enrollee. We will make the most of every contact with a medical, BH or CBO provider to educate them on the value of LTSS services and, on options available to support Enrollees.

4. LTSS Care Coordination

Today, CCHP/LTSS staff provide care coordination services to Enrollees to help them navigate the service delivery system and access the most appropriate available care. All CCHP/LTSS organizations excel in this area.

a. Monitoring and Managing the Member's Status

We will leverage CCHP/LTSS's existing care management and care coordination processes, to monitor and manage the member's status and life events. The LTSS CP Care Coordinator will monitor and implement the Enrollee's Care Plan and ensure that services are relevant, appropriate and satisfying to the Enrollee. Our processes include:

- Conducting home safety assessments as part of the planning process
- Linking the Enrollee to community-based resources and social supports (housing, food, benefits)
- Facilitating LTSS treatment planning with the Enrollee and Care Team to develop the LTSS Care Plan
- Contacting the Enrollees Primary Care Provider (PCP) to coordinate LTSS services and obtain PCP sign-off
- Meeting with the Enrollee when their condition changes (e.g., the visit the ED multiple times, they experience an inpatient admission, they lose a caregiver, or they become homeless) to reassess their level of need
- Addressing barriers to care, such as transportation or other critical services that support the Enrollee in their efforts to remain independent in the community
- Supporting Enrollees during transitions between levels of care.

Through our relationships with ACOs providers and other stakeholders we will coordinate care and facilitate Enrollee access to LTSS.

b. Supporting Enrollee's Ongoing Engagement in Care

We accept and appreciate all Enrollees, protect their rights, and prevent or eliminate discrimination and stigma wherever possible. Our existing Care Coordinators are trained to actively listen to the Enrollee's perspectives and beliefs, and to ask questions to fully understand their impact on the Enrollee's choices. LTSS CP will continue to provide the same level of active listening for each LTSS CP Eligible individual. During each interaction, our Care Coordinator will seek to develop a trusting relationship with the Enrollee and empower him/her to verbalize his or her opinions. We will continue to train staff to enhance Enrollee engagement including, but not limited to, self-identification of goals, and recovery/resiliency opportunities.

To further promote Enrollee engagement, LTSS Care Plans will focus on the individual's life goals and incorporate his/her strengths, opinions and needs in a culturally and linguistically appropriate manner.

5. Support for Transitions of Care

Through our affiliated partners, the LTSS CP brings a wealth of experience in managing transitions in care. We will leverage their effective processes to provide Enrollees with informed choices, make sure supports are in place to enable successful transitions in care, and ensure Enrollee's stability and satisfaction post-transition.

a. Enabling Successful Transitions

Providing Informed Choice. CCHP/LTSS will ensure that the Enrollee and their family/caregiver have a full understanding of the benefits and services available to meet their needs as they transition from an institutional setting back to the community. We will train staff to provide unbiased information about LTSS to help the Enrollee determine the next steps to take following a transition of care. Based on the Enrollee's choices, we may also refer them to a regional Aging and Disability Resources Consortia (ADRC) for choice counseling. We will work with CBO partners to provide efficient access to LTSS for individuals regardless of age, income or disability.

Throughout the care planning process, staff will educate Enrollees on available resources, tools, and treatments, and encourage Enrollees to make informed choices, based on our Community First philosophy and approach. We will not only inform the Enrollee of their LTSS options but will document the options presented to the Enrollee in their record. Enrollees will consistently be offered a choice of at least two providers per service option.

Ensuring Supports are in Place. As part of the transition process, CCHP/LTSS will assign a Care Coordinator to facilitate coordination among LTSS providers and, among Care Team participants. At a minimum, LTSS Care Coordinators will be responsible for the following activities to support Enrollees transitioning between levels of care:

- Contacting the Enrollee to complete an assessment and update their LTSS Care Plan to reflect their status, with the benefit of assessment data from the ACO
- Proactively participating in discharge/transition planning with the Enrollee, facility, and providers
- Contacting the Enrollee's PCP to coordinate discharge planning and follow-up services
- Educating the Enrollee on available services and supports to assist them in transitioning to the community
- Updating the Enrollee's LTSS Care Plan in coordination with the Care Team
- Making referrals for services delivered by other systems (medical care)
- Arranging for follow-up services and ensuring that such services are delivered, based on the Enrollee's needs as they define them
- Connecting the Enrollee to community-based supports

b. Ensuring Enrollee's Stability and Satisfaction Post-Transition

The Care Coordinator will contact the Enrollee within 24 hours of discharge to make sure they understand their discharge instructions, answer questions, verify that the Enrollee has their medications and knows how to take them, and remind the Enrollee of follow-up appointments. The Care Coordinator will conduct regular and ongoing follow-up based on the Enrollee's needs to make sure the Enrollee is receiving all needed services, assess his/her progress toward treatment goals, and determine the need to update the Care Plan. The Care Coordinator also facilitates communication between Care Team participants to promote care coordination.

The LTSS Care Coordinator will review Care Plans with the Enrollees during transitions and assist in developing an appropriate plan, given the Enrollee's needs at the point of transition. The Care Coordinator will participate in the ACO's discharge planning and transition process directly, wherever possible.

CCHP's Care Coordinator will follow-up with any Enrollee in transition within three days of discharge from an inpatient stay, skilled nursing facility, chronic disease or rehabilitation hospital to update the care plan and provide transitional care management. Whenever possible, and desired by the Enrollee, the post-discharge visit will occur face-to-face with the goal of connecting the Enrollee to community services and supports, including Flexible Services where appropriate.

6. Health and Wellness Coaching

CCHP/LTSS will infuse health and wellness information throughout all LTSS service delivery with the goal of assisting Enrollees in preventing chronic medical conditions by promoting proper nutrition, physical activities, and tobacco cessation. For example, during the care planning process, we will engage Enrollees in evaluating their overall health and wellness. We will support Enrollees in incorporating health and wellness goals into their treatment plans when they identify a desire to do so. Examples of treatment goals related to wellness include: keeping food journals, learning healthy recipes, exercising, and tobacco cessation.

Promoting Proper Nutrition**.** Proper nutrition is important for overall wellbeing. Therefore, Care Coordinators will provide education and coaching on healthy diets in alignment with Executive Order 509 (EO 509) Establishing Nutrition Standards for Food Purchased and Served by State Agencies. Staff will be trained in EO 509 standards so that they can assist individuals in determining healthy food options by reading nutrition labels, knowing recommended serving sizes, reducing sodium, increasing fiber, flavoring food with spices and herbs, and avoiding unhealthy fats. Venture currently utilizes Healthy Eating Officers in programs to assist Enrollees with menu and meal planning.

Through a partnership with the UMASS Extension Program, Enrollees will have access to groups and trainings on healthy eating, including cooking demonstrations in programs. Staff also assist people in finding resources for healthy eating, including providing information on local farmer's markets that accept SNAP benefits.

Encouraging Physical Activity**.** CCHP/LTSS organizations will encourage Enrollees to stay active by:

- Learning about the benefits of regular physical activity

- Offering regular opportunities for exercise including walking groups, gym memberships, and exercise equipment in programs
- Assisting individuals in attending fitness classes
- Hosting agency-wide physical activities including kickball, chair volleyball, and basketball tournaments
- Conducting an annual "fitness challenge" in which individuals and staff participate and log their physical activities; participants receive T-shirts, water bottles, and other fitness swag

Promoting Tobacco Cessation. We are aware of, and concerned about the long-term effects of tobacco use in our individuals and actively promote tobacco reduction and smoking cessation. Staff who are trained and certified as Tobacco Treatment Specialists (TTS) provide education on the benefits of smoking cessation. We run smoking cessation groups, and provide individuals with resources and supplies to quit smoking. Individuals who are not interested in quitting are encouraged to reduce the amount of tobacco used. TTS staff also do 1:1 work with individuals on tobacco treatment. Each year the agency promotes and participates in the Great American Smoke Out and provides bag with supplies to quit smoking to staff and individuals who are interested.

7. Connecting Enrollees to Social Services and Community Resources

We recognize that, to improve Enrollee health and assist them in achieving their goals for independence, we must address their holistic health needs. We promote integration of care across physical, behavior health, LTSS and social services through our Comprehensive Assessment, care planning, and ongoing care coordination processes.

a. Evaluating Enrollee Social Service Needs

CCHP/LTSS employs a person-centered approach that considers the total care needs of Enrollees with LTSS needs. We will foster an integrated system of care by collaborating with medical providers, Care Coordinators, ACOs and MCOs, and other stakeholders to identify psychosocial needs that can be met by social services and supports agencies. CCHP will use the ACO's Comprehensive Assessment; we will further work with our partner ACOs to discuss the financial and operational feasibility of having CCHP/LTSS staff conduct a specific LTSS assessment using our extensive knowledge and skills.

Additionally, we will jointly develop processes and procedures with ACOs in our service area to collaborate and coordinate in the delivery or facilitation of access to Flexible Supports authorized by the ACO. Care Coordinators will work with ACO Care Coordinators for Engaged Enrollees to identify supports (as documented and authorized by the ACO) and jointly establish a plan for providing or arranging for them (as appropriate). Such services will be included in the Enrollee's Care Plan and monitored by the Care Team. Specific strategies for collaborating with ACOs and MCOs include our desire, pending contract negotiation with the ACO, to:

- Provide the ACO or MCO a detailed orientation to our organization, services provided or facilitated, structure and operations of our Care Team model, and contact information

- Establish and facilitate joint processes to conduct Comprehensive Assessment and care planning meetings with the Enrollee under a single integrated care management team
- Establish and maintain a cadence of periodic joint case conference meetings to discuss especially challenging joint cases (telephonic, WebEx, face-to-face) to ensure appropriate communication, collaboration, follow-up and accountability
- Develop and maintain a common community resource directory for Enrollees and staff
- Conduct joint trainings (initial and periodic) for care management and care coordination staff
- To the extent allowed by the Enrollee, share care plans, progress reports, status reports, and other pertinent information about Engaged Enrollees with the ACO and MCO partners

b. Ensuring Ongoing Connections to Community Resources and Social Services

CCHP has longstanding existing relationships with community and social service agencies in our service area and will leverage these relationships to ensure access to needed supports and Flexible Services. We have processes in place to provide referrals and coordinate with community services providers and social service agencies and will leverage these existing processes to facilitate ongoing communication and information-sharing and ensure that Enrollees have timely access to needed community supports.

Our formal current and planned approaches include:

- Developing comprehensive referral and community resource guides for Engaged Enrollees and CP staff
- Appointing dedicated points of contact
- Executing memoranda of understanding with providers and community organizations regarding the delivery and coordination of services
- Appointing liaisons to foster relationships and communication with community agencies

Through their care coordination processes, staff follow up with all providers, systems, and organizations to make sure the Enrollee receives all services and supports in accordance with the integrated care plan.

D. Innovative Technologies for Service Delivery

As part of its regular outcome evaluation and quality improvement processes, Alternatives became aware of the fact that it served many individuals in its day habilitation and residential programs who were severely limited in their ability to communicate their basic needs or learn new skills. To address this need, Alternatives partnered with students from Clark University to explore the use of available technology to facilitate individual improvement and satisfaction. Clark assessed individuals' adaptive skills in all 5-day habilitation programs and developed a proposed menu of software products for IPads which individuals with cognitive limitations could use (with some adaptations) to learn new skills and engage in recreational activities.

The agency invested in several IPads for each day habilitation program. Results from the first year indicated a high level of satisfaction and success. Individuals increased the length of time they remained engaged, their observable level of enjoyment appeared to grow, and they used a

variety of programs for learning, fun, and communication. The staff are now evaluating the software programs to determine those that were less engaging or too difficult and finding new software to replace them

CM Platform to Monitor Utilization, Care Management, Activity Counts. CCHP/LTSS staff will use mobile technology to improve their ability to outreach and engage Enrollees. In addition to smartphones, Care Coordinators will have laptops or tablets, mobile printing devices, and electronic signature pads. Over time we will enhance the tools available to staff in a manner that improves the Enrollee experience and outcomes.

Our Material Subcontractors, Elder Services of Worcester Area (ESWA) and Center for Living & Working Inc. (CLW), will use their extensive resources and experience to help CCHP/LTSS extend safety nets through comprehensive LTSS programming. Each agency supports a large number of individuals with a wide range of needs and as material subcontractors both ESWA and CLW will be able to assure continuity of care for these individuals assigned to the CP. The agencies will be responsible for integrating care for each of these enrollees and will use existing staff to coordinate through CCHP/LTSS. As the ACO model of care develops, it is possible that ESWA and CLW will be assigned staff by the CP as budgeting allows. Also, the two agencies will be crucial in managing transitions for enrollees leaving nursing homes or hospital care. Each agency is equipped to fulfill this responsibility through the use of existing mobile resources and an array of transition models and experience. ESWA and CLW will also play an important role in options counseling for the enrollees they support as well as for new enrollees seeking assistance in Central Massachusetts. Also, as an Independent Living Center, CLW will assist with assessment and training around mobility issues. As the CP and ACO models evolve over the first five years, each Material Subcontractor will also have a role in staff training and program development that ensures coordination of care that is holistic and innovative. Both agencies will also represent CCHP/LTSS and Enrollees through the Aging Disability Resource Consortium of Central Massachusetts.

E. Personnel and Staffing

1. Organizational Chart

We provide our organizational chart as **Attachment 7.5.E-1**, identifying personnel who will be assigned to accomplish the Contractor responsibilities described in Attachment A of the RFR.

2. Sample Staffing Model

We propose serving approximately 1,000 LTSS CP eligible Enrollees within the defined Service Areas, in year one as detailed in **Attachment 7.2.A**. Our staffing model will include the following positions and number of full-time equivalents (FTEs) in Budget Year one.

Table 7.3.E.2. Staffing Model

Positions	FTEs
Administration	
Director	.19
Quality Manager	.19

Positions	FTEs
Referral Coordinator	.19
Administrative Assistant	.19
Supervisors	0
Senior Clinical Care Manager	1
Care Management	
Clinical Care Manager (1-8)	1
Care Coordination	
Care Coordinators (1:70)	6
TOTAL	9.5

3. Description Recruitment Plans

Upon award, we will begin recruiting for Managers and Care Coordinators. We will work with the ACO/MCO's to determine eligible Enrollee numbers and geography in our service area to aid in planning for the staff needed for program launch in April. We anticipate starting the program with 8-10 Care Coordinators and 1 Care Manager/RN. Recruitment will continue for additional Care Coordinators as the program grows. We will continue to recruit for positions in advance of program growth, using the budget periods as milestones for assessment of enrollment and attrition rates, so that all staff is appropriately trained before they interact with individuals served.

CCHP/LTSS will expand partnerships with local colleges to recruit staff through career fairs, internships, shadowing, and may include innovative programs like student loan payment stipends.

Table 7.3. E.3. Recruitment Plan

Position	Begin Recruitment	Target Hire Month
Director	October 2017	December 2017
RN	Will be recruited as one of two Sr. Care Managers (see below)	
Care Coordinator	December 2017	April 2018
Referral Coordinator	December 2017	March 2018
Admin Assistant		
Quality Analyst	December 2017	February 2018
Sr. Care Manager	December 2017	March 2018
Care Manager	December 2017	March 2018

Job descriptions are provided as Attachment 7.5.E-3.

4. How We Will Recruit and Hire Staff from the Cultural and Linguistic Communities

CCHP/LTSS will ensure that staff is representative of the communities we serve. We recognize that "culture" encompasses more than linguistic diversity, and includes racial or ethnic background, national origin, immigration/refugee experience, physical or mental disability, gender and gender identity, and sexual orientation.

To that end, we will ensure that our providers, staff, and volunteers are responsive to the linguistic, cultural, ethnic, or other unique needs of all Enrollees. We will assess our current capacity and competencies through an initial survey of provider and staff about CP supports and cultural diversity. We will also use existing community needs assessments and studies, and will work with our ACO and MCO partners to maintain ongoing demographic, cultural, and epidemiological profile of the community.

CCHP/LTSS will use community profiles to identify hiring priorities, and training needs to increase staff sensitivity to the needs of Enrollees from different cultural and ethnic backgrounds. We will work closely with community-based organizations (e.g. immigrant and refugee coalitions, advocacy coalitions, LGBTQ advocacy agencies) to identify and leverage opportunities for targeted recruitment activities. We will also partner with ACOs and MCOs to conduct job fairs in specific communities and in languages other than English, where possible.

5. Description of How We Will Ensure That All Staff Meet the Competencies and Trainings Requirements

CCHP/LTSS' training programs will provide staff with an understanding and awareness of Enrollees with LTSS CP needs. We will train our staff on key topics using existing training modules. Refresher training, as well as updated training on best practices, will occur at least annually. We will finalize training modules and training schedules before the contract effective date. Below are examples of potential training modules.

Listing of Proposed Training Modules	
Understanding and awareness of the needs of Enrollees with LTSS needs	• Chronic Illnesses • Intellectual, Cognitive, and Developmental Disabilities • Medical Care and Coordination • LTSS Services: What are LTSS Services, Who Provides them, and How Do We Work Collaboratively?
Understanding Community Partner Supports	• Scope of services • Partnership and Collaboration with ACOs/MCOs • Comprehensive Assessment and Treatment Plan • Flexible Service: Resources, referral, follow-up • Collaboration and Communication with community agencies
Cultural Perspectives – Recognizing sensitivities to different cultures, religions, values, and backgrounds	• The Impact of Culture on health and health care • Health Disparities • Culturally Competent Behavioral Health Care Delivery • The LGBTQ Community

Staff training will be facilitated by: enabling staff to participate in mandatory training during work hours; tracking participation electronically through a learning management system (LMS); enabling online evaluations and scoring; providing resource guides and training materials to reinforce learning.

We will incorporate existing MassHealth training and resources into staff trainings and material, encourage staff to participate in MassHealth training forums and ensure staff who interact with Enrollees with BH needs complete required training on BH competencies. In addition, Alternatives and its Affiliated Partners have deep training resources within their organizations and currently provide tens of thousands of hours of training on a broad array of relevant topics including many recognized as evidence-based practices.

CCHP/LTSS is also considering the Providers' Council E-Academy training program as well as an in-house mentoring program created by Venture to support professional growth and development. We will partner with ACOs and MCOs to hold periodic conferences for Enrollees, staff, advocates, BH-CPs, social service and community agencies that will provide opportunities for them to learn from Subject Matter Experts (including experts from the ACOs, MCOs, and ILCs). When possible, we will collaborate with ACOs and MCOs to develop and deliver trainings on topics of mutual and common interest, such as care coordination strategies, community collaboration, and cultural competence.

6. Description of the Staff Retention Strategy

In our experience, there are systemic challenges and barriers to recruiting and retaining qualified, trained and experienced staff. We believe that addressing these challenges requires a long-range, comprehensive, multi-pronged strategy, including ongoing career development, educational assistance, on-going licensing and credentialing opportunities, and leadership training.

In the short term, we will explore using DSRIP funds for certain defined workforce development initiatives, including staff retention efforts. We propose collaborating with other LTSS CPs, ACOs, MCOs, and industry groups to explore opportunities for collaborative efforts to develop and implement staff retention programs, including professional development. Potential areas of focus to be evaluated may include:

- Strategies to encourage workforce to continue to earn degrees in higher education and professional credentials through current tuition reimbursement programs
- Provide leadership training and mentoring to staff who seek to advance in their careers
- Provide on-going opportunities for continuing education for licensing and credentialing

We believe that being able to raise salary levels and benefits will likely result in better retention, but the current environment will allow for this. However, there are additional non-financial benefits that can also aid in retention by improving staff experience in the workplace. These include:

- Foster an enhanced sense of ownership and accountability among staff by expanding our existing mechanisms to solicit, obtain, and incorporate (to the extent appropriate) staff input into program development, administration, and management

- Cultivate a supportive organizational culture by providing more focused and personalized management, supervision, and mentoring
- Exploring opportunities to reduce the administrative burden on staff by streamlining recordkeeping and other documentation requirements
- Exploring and implementing creative work allocation and scheduling to allow staff to achieve a healthy work-life balance.

F. Implementation Plan and Timeline

Timelines with implementation plans are included in **Attachment 7.5.F.**

G. Budget Report and Budget Narrative

The Budget Report is submitted as **Attachment 7.5.G-1**. The Budget Narrative is submitted as **Attachment 7.5.G-2**.

H. Sustainability

CCHP/LTSS will sustainably fund proposed infrastructure, capacity building investments and LTSS CP supports through:

- DSRIP Dollars (initial investment and ongoing funds distribution associated with volume)
- Shared savings initiatives developed over time with the ACOs/MCOs
- The ability to sell services to MCOs for non-CP eligible individuals who can benefit from CP services to manage the total cost of care for more Enrollees
- Managing fixed costs associated with IT, licensing, fees and general expenditures over time
- Identifying and developing new services for ACO, MCO, and commercially enrolled individuals to help individuals remain independent in the community and decrease the total cost of care associated with avoidable hospital utilization.

I. Quality Management and Performance Monitoring

1. Description of the Quality Improvement Program

CCHP/LTSS will collaborate with our affiliates to create a Quality Management and Quality Improvement (QM/QI) Program for this proposed LTSS CP. Our QM/QI program, which will support our mission, will measure and improve: clinical quality of care; care coordination; access and availability; continuity; and Member experience. Through our QM/QI program, we will apply a data-driven, evidence-based approach to service delivery and analyze and compare data against internal, local, and state benchmarks to identify opportunities for improvement. Our QM/QI program will establish goals, processes, and include an interdisciplinary committee structure with Enrollees and family members and representatives from each affiliated partner.

Applying Principles of Continuous Quality Improvement

CCHP/LTSS's QM/QI Program will be based on continuous monitoring of quality performance measure indicators, clinical practice guidelines and activities. Our goal is to deliver quality care that helps Enrollees maintain and improve health and wellness. Our objectives are to: improve clinical quality; improve coordination of care; improve access to services; and, enhance all aspects of the Enrollee experience. We will achieve our goal and objectives by relying on data-

driven decision making, evidence-based practices and expert advice – all of which will be used to drive improvement. These goals will form the basis of our QM/QI program and provide areas of focus that drive our improvement strategies. We will work to continuously improve care by:

- Using data to identify and address anomalies in care and outcomes
- Developing interventions to ensure that goals are achieved
- Completing objective measurement processes and implementing improvement initiatives

The information used for quality monitoring and improvement derives from several sources including but not limited to: medical record review, member and/or provider complaints, utilization review, and survey data.

The QM/QI Program will define clear assignment of roles and responsibilities to each affiliated partner; performance benchmarks in alignment with program goals and contractual requirements; and Enrollee satisfaction measures. Further, the program will include meaningful roles for Enrollees and their families in QM/QI activities on advisory councils; monitoring processes to review medical record-based studies; and, plans to monitor care management. Using a continuous quality improvement approach, we will compare our outcome results to prior year results to assess our performance in meeting goals, and advance performance by establishing outcome objectives for the next year.

QM/QI Plan

Our QM/QI Plan and Annual Work Plan will constitute the blueprint for all quality goals and describe the activities that the LTSS CP will undertake to address all contractual QM/QI requirements. As outlined in the QM/QI Plan, we will collect and analyze qualitative and quantitative data to drive quality improvement initiatives. The QM/QI Plan will be a responsive, dynamic document and we will continually update it based on stakeholder input and data analysis. CCHP/LTSS will also maintain an Annual Quality Work Plan that delineates a core set of performance metrics and is updated based on the annual review of systems. The Work Plan will define strategies to address priorities outlined in the QM/QI Plan.

Annually, CCHP/LTSS will conduct a comprehensive program assessment that examines QM/QI program effectiveness, service utilization, cost, quality data, the prior year's outcomes, and compliance with contractual requirements. Progress toward goals will be reported to the Quality Committee, which will determine opportunities for improvement and design interventions and track the effectiveness of interventions. In this way, we will ensure our QM/QI program is relevant to the population we serve and results in better care for Enrollees.

2. Description of at Least One Quality Initiative

CCHP/LTSS is committed to improving Enrollee care by enhancing the quality of services we provide. To that end, we propose to implement a quality initiative related to enhancing care coordination for high-cost, high-risk Enrollees served by the MassHealth program. Specifically, as described below, we plan to implement an initiative that seeks to increase the number of Care Team meetings in which the LTSS actively participates to create a single Care Plan in collaboration with the ACO.

Description: CCHP/LTSS will establish a protocol with each ACO in our geographic service area designed to promote the creation of a single Care Plan that includes LTSS for Enrollees who are LTSS CP eligible.

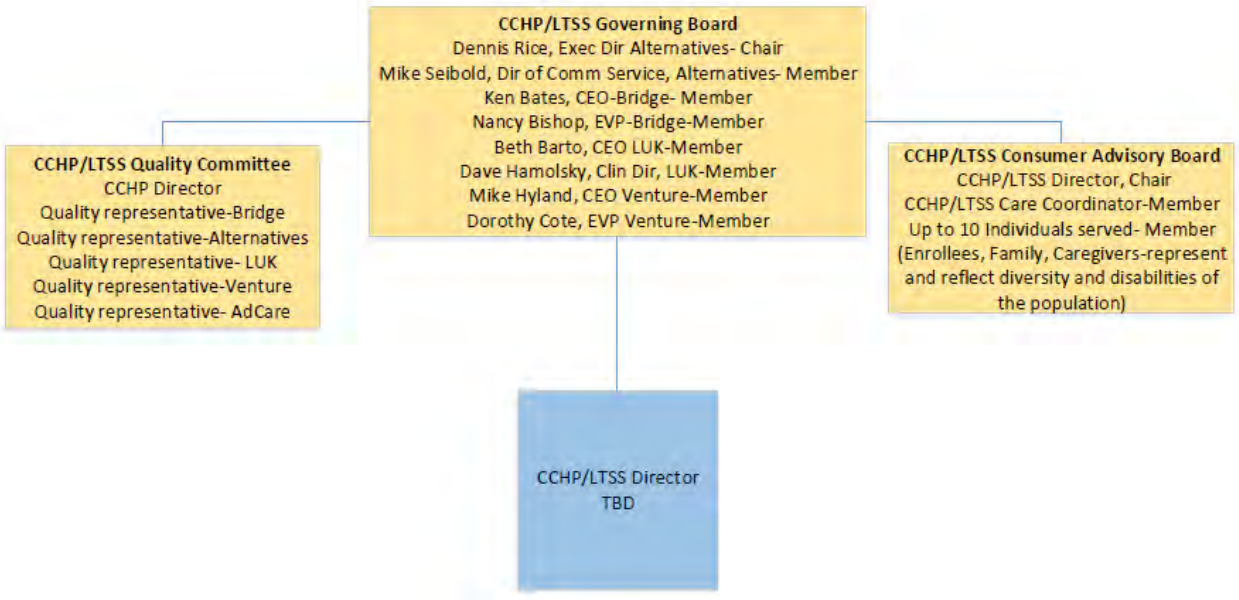
Target Population: The target population for this initiative includes individuals who are LTSS CP eligible and Engaged Enrollees.

Measures for Success: Data related to this initiative will be continuously monitored through our Quality Committee. Measures of success will include:

- The percentage of Integrated Care Plans that include a CCHP/LTSS Care Plan as part of the overall ACO Care Plan
- The percentage of ACO care planning meetings that CCHP/LTSS Care Coordinators are invited to attend
- The percentage of Enrollees that meet their LTSS goals documented in the Care Plan

3. Functions of the Quality Management Committee

CCHP/LTSS will maintain a multidisciplinary committee structure that drives quality improvement through the review of quality data, includes representatives from each affiliated partner, and incorporates Enrollee and family feedback. Our Quality Committee will meet monthly and be responsible for: identifying quality improvement opportunities; finalizing intervention strategies to improve quality and cost effectiveness; establishing timeframes for interventions; and tracking the effectiveness of interventions and making modifications to improvement strategies, as needed. The Quality Committee will report to the Governing Board as shown below.



Our Committee structure will include:

Governing Board: The Governing Board will include two representatives from each affiliated partner and the CCHP Executive Director, all of whom have voting rights. This committee will

serve as the decision-making authority for the LTSS CP and provide strategic direction and programmatic oversight. The Governing Board will be chaired by the LTSS Director.

Quality Committee: Performance data will be reported to the Quality Committee which analyzes data against program goals and develops performance improvement initiatives. This committee will meet monthly and include one representative from each affiliated partner and will be chaired by the LTSS Director.

Consumer Advisory Board (CAB): The CAB will be responsible for ensuring that services delivered are consistent with our mission and values, identifying service gaps and solutions to address them, and gathering direct feedback regarding service delivery from individuals served and direct care workers. Information gathered from our CAB will be used to inform changes in policy and practice. The Board will be composed of a total of ten consumers and two CCHP/LTSS Employees, one of which will be the Director.

J. Coordination with ACOs and MCOs

1. How We Will Communicate Our Skills, Expertise, and Value to Potential ACOs and MCOs

We have already initiated discussions with ACOs and MCOs in our service area to discuss our skills, expertise, and value to care integration efforts. Such discussions will continue over the next several months as BH CP, LTSS CP, ACO and MCO contracts are awarded by EOHHS. We are communicating with and will continue to educate ACOs and MCOs regarding:

- Shared responsibility in caring for MassHealth Enrollees with the greatest needs and level of risk.
- The contribution that the LTSS CP can make to delivering quality care for Enrollees with LTSS needs. We will positively impact integration, Enrollee satisfaction and the total cost of care among other measures, all of which will be vitally important to Enrollees and our organization, ACOs, and MCOs, and facilitate our joint efforts to deliver care.
- The breadth and depth of LTSS CP services available to Enrollees who are eligible for such services. For example, we will discuss the specialized nature of the LTSS Care Plan and ongoing care plan implementation and monitoring.
- The importance of primary care delivery for Enrollees with LTSS needs, many of whom go without primary care services for a variety of reasons.
- Collaborative strategies to integrate care for LTSS CP eligible Enrollees in the assessment, care planning, and care delivery process.

2. Branding and Marketing Plan

CCHP/LTSS's Marketing and Branding Plans will be guided by MassHealth policy and procedure, which clearly prohibits MassHealth vendors from directly marketing to Enrollees. Our priority will be to serve Assigned Enrollees who have a pre-existing relationship with our organization and, those who are Assigned by the ACO.

For Marketing and Branding, our organization plans to:

- Focus on public awareness of health and wellness as well as ACO and LTSS service delivery
- Develop an awareness campaign of the value of BH CP services for Enrollees with LTSS needs to enhance access to services. Materials will be made available to ACOs and MCOs in the most commonly spoken languages in the service area and will be distributed to Enrollees as part of the Enrollment process.
- Educate ACO and MCO partners regarding our services, our approach to Enrollee services and the nature of integration we offer, which will benefit Enrollees.

3. Strategy to Engage and Collaborate with Multiple ACOs and MCOs

CCHP will provide information to all ACO and MCO partners in the Service Areas for which this bid applies. We will care for Enrollees who are assigned by or enrolled in any ACO in the Service Area and will work to develop processes that promote care integration and coordination with the full provider network. Ultimately, our goal is to provide care that is satisfying to Enrollees.

4. Strategy for Conflict Resolution

CCHP/LTSS will partner with ACOs and MCOs in the Service Area to serve the needs of Enrollees with LTSS needs. We will build upon the strengths of our organization. While we do not anticipate disagreements in areas of shared responsibility, we recognize that differences of opinion may arise, specifically related to Care Management decisions that affect Enrollees or, the way the Contract is managed. Our mutual intention is to resolve those disagreements promptly that causes no harm whatsoever to Enrollees and, maintains compliance with the terms of the contract.

K. Providing Culturally Competent and Informed Services

1. Providing Effective, Equitable, and Respectful Supports

a. Providing Language/Communication Assistance

CCHP/LTSS will provide language/communication assistance, including access to qualified interpreters, for Enrollees with Limited English Proficiency, deaf Enrollees, Enrollees who are hard of hearing and Enrollees with cognitive disabilities through multiple mechanisms. For Enrollees who require interpreters, CCHP/LTSS will make available and/or hire individuals who speak the major languages spoken within the Service Area. If staff who speak a language is not available, CCHP/LTSS will contract with the ATT Language Line, which will be available 24/7.

For Enrollees who are deaf or hard of hearing, CCHP/LTSS will provide qualified staff who can expertly communicate with Enrollees in ASL. We will also provide written materials in alternative formats, ensuring that such information is accessible to Enrollees. For individuals with Cognitive Disabilities, our staff will work with the Enrollee to communicate at their level; for individuals with guardians or involved family members/caregivers, we will collaborate with them to communicate with the Enrollee. We plan to use CDI, CART, Relay Services, Video Phone, Braille,

Large Print, and accessible computers in our day to day operations and special events. We will also use assistive listening devices that are readily accessible for Enrollees or staff

b. Informing Enrollees of Available Language and Communication Assistance

CCHP/LTSS will make information available to Enrollees, families, and caregivers regarding the availability of multi-lingual services and communication assistance. At the outset of meetings with the Enrollee and their family, CCHP/LTSS will obtain information regarding the Enrollees' language preference of format, and we will respect that choice as appropriate.

c. Being Responsive to Diverse Cultural Beliefs and Practices

CCHP/LTSS understands the critical role that culture, ethnicity, and equal opportunities play in health. Today, our affiliate's processes are designed with the Enrollee at the center of their care while respecting their language, age, race, ethnicity, preferences, beliefs, or disability. During the screening process, we offer the Enrollee the opportunity to self-identify any cultural preferences that impact the way they view and access services. If the preference impacts other areas of the Enrollee's life (isolation, depression), we conduct an assessment to guide our next steps and engage the Enrollee in appropriate care. Information from the assessment is incorporated into the Enrollee's LTSS Care Plan, and we make appropriate referrals to community services that specialize in serving Enrollees with diverse needs.

2. Expertise and Experience Providing Care to Special Populations

a. Individuals experiencing homelessness

CCHP/LTSS partners work closely with individuals experiencing homelessness. In fact, The Bridge of Central MA, Inc. is a Public Housing Authority (PHA) providing Section 8 tenant-based assistance under the housing choice voucher program funded through the US Department of Housing and Urban Development (HUD). The Bridge works closely with Worcester's Executive Office of Economic Development, Office of Housing Development on a program funded through ESG (Emergency Solutions Grant) to provide support for homeless individuals who have mental health and substance use challenges. The Bridge also serves on the Worcester County Continuum of Care and partner with the Central Massachusetts Housing Alliance and others in working to address homelessness in the region. As another example, Alternatives has longstanding working relationships with the Worcester, Leominster, Fitchburg and Milford Housing Authorities and several other city and town authorities who administer a variety of Federal and State affordable housing and subsidy programs. Through these programs, we have secured housing resources that support hundreds of individuals who would otherwise experience high risk for homelessness.

b. LGBTQ populations

The Bridge offers The Safe Homes program for LGBTQ youth ages 14-23 and works closely with City Manager Ed Augustus and Mayor Joe Petty who have been staunch supporters of the program. City leaders have actively participated in and supported the annual Safe Homes People

of Courage event to recognize leaders who have exhibited courage in social justice, advocacy and action.

c. Criminal Justice-involved individuals

CCHP organizations have long-standing relationships with correctional facilities, probation departments, reentry programs, courts, and police departments throughout Central MA. For example, The Bridge trained the entire Worcester Police Department on how to work more effectively with people in crisis who have a disability.

d. Individuals who are blind, low vision, deaf or hard of hearing

CCHP/LTSS partners have experience caring for individuals who are deaf or hard of hearing. For example, Alternatives has had long-standing working relationships with DMH and DDS area offices throughout the Central Region and has successfully provided services through service contracts for the past 40 years. Alternatives also provides culturally competent care management deaf services to Enrollees through our team of staff who themselves are deaf.

e. Individuals with cognitive disabilities

As described throughout this RFR submission, CCHP/LTSS organizations have four decades of experience serving individuals with cognitive disabilities. For example, Alternatives serves individuals in Day Habilitation and AFC programs with cognitive impairments due to head injury as well as individuals who experience cognitive decline as the result of aging. Additionally, The Bridge provides community support and residential services under acquired brain injury (ABI) waivers to help Medicaid-eligible persons with ABI and cognitive disabilities move to the community and obtain community-based services. This includes providing assistance with transitioning individuals to the community from Nursing and Rehabilitation facilities.

Community Partner Program Budget Report

Alternatives Unlimited, Inc.

	Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
	Estimated Enrollees- Start of Period (All Enrollees)		600	1,036	1,301	1,486	1,617	
	Estimated Enrollees - End of Period (All Enrollees)		1,036	1,301	1,486	1,617	1,734	
	Estimated Enrollees - Monthly Average		823	1,181	1,413	1,554	1,684	
	Total Estimated Program Revenue		**$ 460,880**	**$ 1,133,760**	**$ 1,356,480**	**$ 1,491,840**	**$ 1,616,640**	**$ 6,059,600**
	At- Risk Withhold Rate			0%	0%	0%	0%	
	Withhold funds			$ -	$ -	$ -	$ -	$ -
	Revenue for Operations		$ 460,880	$ 1,133,760	$ 1,356,480	$ 1,491,840	$ 1,616,640	$ 6,059,600
	Program Expenses	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
1	**Salary**	$ 71,875	$ 353,017.00	$ 823,343.00	$ 865,316.00	$ 968,086.00	$ 1,033,176.00	$ 4,042,938.00
2	**Fringe**	$ 17,875	$ 87,795.00	$ 204,766.00	$ 215,204.00	$ 240,763.00	$ 256,951.00	$ 1,005,479.00
	Total Personnel Costs	$ 89,750	$ 440,812	$ 1,028,109	$ 1,080,520	$ 1,208,849	$ 1,290,127	$ 5,138,167
3	**Training & Professional Development**	$ 2,000	$ 3,526	$ 6,511	$ 6,688	$ 5,096	$ 5,379	$ 27,200
4	**Travel**	$ 655	$ 9,188	$ 22,595	$ 24,033	$ 26,472	$ 28,643	$ 110,931
5	**Equipment**	$ -	$ -	$ 556	$ 750	$ 750	$ 750	$ 2,806
6	**Supplies**	$ 1,891	$ 6,188	$ 7,446	$ 9,220	$ 10,238	$ 10,593	$ 43,685
7	**Contract Services** (consulting, professional)	$ -	$ 7,731	$ 11,880	$ 11,880	$ 11,880	$ 11,880	$ 55,251
8	**Software licensing**	$ -	$ 17,290	$ 42,499	$ 50,854	$ 56,016	$ 60,609	$ 227,268
9	**Telecommunications**	$ 2,000	$ 3,815	$ 8,778	$ 9,219	$ 10,239	$ 10,948	$ 42,999
10	**Occupancy** (rent, utilities, maintenance)	$ 22,418	$ 57,576	$ 61,840	$ 69,955	$ 87,707	$ 85,914	$ 362,992
11	**Other**	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Total Direct Costs	$ 118,714	$ 546,126	$ 1,190,214	$ 1,263,119	$ 1,417,247	$ 1,504,843	$ 6,040,263
12	**Indirect Cost/Administrative Overhead** **12.5%**	**$ 14,839**	**$ 68,266**	**$ 148,777**	**$ 157,890**	**$ 177,156**	**$ 188,105**	$ 755,033
	TOTAL EXPENSES	$ 133,553	$ 614,392	$ 1,338,991	$ 1,421,009	$ 1,594,403	$ 1,692,948	$ 11,933,463
	Surplus/Shortfall	*$ (133,553)*	*$ (153,512)*	*$ (205,231)*	*$ (64,529)*	*$ (102,563)*	*$ (76,308)*	*$ (602,143)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Referral Coordinator	$ 55,000.00	0.5	3	$ 6,875
Senior Clinical Care Manager	$ 65,000.00	1	3	$ 16,250
Clinical Care Manager	$ 60,000.00	1	3	$ 15,000
Care Coordinator	$ 45,000.00	6	1.5	$ 33,750
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary (Program Budget Line 1)		**8.5**		**$ 71,875**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 71,875.00	24.87%	$ 17,875
Total Fringe (Program Budget Line 2)			**$ 17,875**

Total Personnel*	**$ 89,750**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:
Referral Coordinator *- Building and strengthening business relationship with the ACO/MCO. Distribute enrollee information to care teams to engage for enrollment in preparation for Go-Live.*
Senior Clinical Care Manager *- Oversee the LTSS component of CP. Recruit, hire, train, and supervise the LTSS Clinical Care Managers in support of CP contract requirements. Requires RN or Licensed Clinician.*
Clinical Care Manager *- Participate in various trainings to provide integrated care coordination and management for individuals to be enrolled in the program in accordance with CP contract requirements. Requires RN or Licensed Clinician.*
Care Coordinator *- Provide integrated care coordination and management for individuals to be enrolled in the program in accordance with CP contract requirements.*

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Training and staff orientation		8	$ 2,000.00
Total Training and Professional Development (Program Budget Line 3)			**$ 2,000.00**

Provide a description of each Training and Professional Development line item included in the table above:

Staff training - Training and orientation to be provided to the staff hired in the preparatory period specifically for program onboarding and care management platform training.

The Central Community Health Partnership will form a combined orientation and training group for staff hired into the CP program. Newly hired staff will be oriented into their employer organization and then by the Central Community Health Partnership training collaborative. New employees will be oriented into the service delivery system of CP services and the service delivery standards of the model Minimally, we will maintain annual refresher training days or updates if there is a significant change to service expectations.

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
Staff Travel	366	3	0.45	$ 494.10
				$ -
				$ -
				$ -
				$ -
				$ -
			Total Mileage	$ 494.10

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Travel Expense Description	Cost
Total Mileage	$ 494.10
Parking and tolls	$ 161.00
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ 655.10**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

Staff Travel - staff mileage paid to staff for travel to meetings with affiliated partners, ACOs, and MCOs. Mileage is also paid to staff for travel to off-site trainings, conferences, etc. The staff mileage will be paid to all staff included in Row 1 as well as all staff included in the Infrastructure budget Row 12.

Row 5 - Equipment

Description of Equipment	Unit Cost	#units or FTEs	Cost
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
Total Equipment (Program Budget Line 5)			

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Office Supplies	1891	1	$ 1,891.00
			$ -
			$ -
Total Supplies (Program Budget Line 6)			**$ 1,891.00**

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Office Supplies: Our supply manager analyzed the costs per item and needed inventory to stock the start up of this program including desktop items, e.g., staplers, paper clips, pens, etc. as well as supplies for printers, copiers, etc.

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Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost

	A	B	C	D	E	F
137	**Total Contract Services (Program Budget Line 7)**			**$ -**		
138						
139	***Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the***					
140	***CP's performance and how the costs for each were determined. Note that a Statement of Work must also be***					
141	***submitted to EOHHS.***					
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169	**Row 8 - Software Licensing**					
170	**Description of Software**	**Cost per License**	**# Licenses**	**Cost**		
171				$ -		
172				$ -		
173				$ -		
174			**Total Software Licensing**			
175			**(Program Budget Line 8)**			
176						
177						
178	***Provide a brief description of how each Software Licensing line item listed above will support the CP's performance***					
179	***and how the costs were determined:***					
180						
181						
182						
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185						

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Telephone monthly service	See below	2	$ 2,000.00
			$ -
			$ -
			$ -
			$ -
Total Telecommunications (Program Budget Line 9)			**$ 2,000.00**

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Cost of monthly telecommunications service for prep budget period calculated at $400/month per each of 2 plans. Alternatives and Bridge locations for 2.5 months each. Other locations to be added in following budget period.

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent, Utilities, Repairs, Insurance (6 month	2300	15	$ 20,125.00
Household Supplies			$ 2,293.00
			$ -
			$ -
			$ -
Total Occupancy (Program Budget Line 10)			**$ 22,418.00**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

Occupancy cost includes the cost of renting space for the LTSS CP program. These expenses include rent, repairs and maintenance to space, utilities, insurance and potential cost of office space used in other partnering agencies. Occupancy cost is estimated at 100 square feet per employee, calcutated for the anticipated 23 FTEs at $ 15 per square foot for a 7 month period. Space need is based upon future projections.

Household Supplies: Costs of initial purchase for cleaning supplies, janitorial services and sanitary items based upon an analysis by our supply manager. This is to cover the first 7 months.

Row 11 - Other Direct Costs

Other Direct Expense Description	Cost
Total Other Direct Costs (Program	
	$ -

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead	**12.5**	**$ 14,839.00**

	A	B	C	D	E	F
332	***Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:***					
333	***Administrative overhead includes:***					
334	***Senior management***					
335	***IT support***					
336	***HR support***					
337	***Property and office services support***					
338	***Business office support***					
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12								
12	Alternatives Unlimited, Inc.							
Infrastructure Investment Funding		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
PMPM Infrastructure Rate		NA	$ 75.00	$ 49.72	$ 43.28	$ 36.40	$ 29.34	
Engaged Enrollees		NA	823	1,181	1,413	1,554	1,684	
Estimated Infrastructure Funds		NA	$ 432,075	$ 704,632	$ 733,856	$ 678,787	$ 592,903	**$ 3,142,252**
At- Risk Withhold Rate				25%	44%	64%	81%	
Withhold				$ 176,158	$ 322,896	$ 434,424	$ 480,251	**$ 1,413,729**
TOTAL MAXIMUM FUNDS AVAILABLE		$ 450,000	$ 432,075	$ 528,474	$ 410,959	$ 244,363	$ 112,652	**$ 2,178,523**
Infrastructure Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology								
1 **IT Staffing including Fringe**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
2 **Development Adaptation of EHR and/or Care Management System**		$ 125,000						**$ 125,000**
3 **Technology for Service Delivery**		$ 15,934	$ 18,530	$ 11,368	$ 9,800	$ 9,800	$ 7,300	**$ 72,732**
4 **Other Technology Expenses**		$ 1,418	$ -	$ -	$ -	$ -	$ -	**$ 1,418**
Total Technology		$ 142,352	$ 18,530	$ 11,368	$ 9,800	$ 9,800	$ 7,300	**$ 199,150**
Workforce Development								
5 **Workforce Development staffing including Fringe**			$ -	$ -	$ -	$ -	$ -	**$ -**
6 **Recruitment Expenses**		$ 7,000	$ 3,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000	**$ 14,000**
7 **Training Expenses**		$ 1,000	$ 2,000			$ -	$ -	**$ 3,000**
8 **Retention Expenses**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Total Workforce Development		$ 8,000	$ 5,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000	**$ 17,000**
Business Start Up Costs								
9 **Office Equipment (PBP & BP1 only)**		$ 31,150.00	$ 30,000.00					**$ 61,150**
10 **Office Furniture (PBP & BP1 only)**		$ 17,600.00	$ 16,000.00					**$ 33,600**
11 **Ramp-up Costs (PBP BP1, BP2 and BP3 only)**		$ 133,553	$ 153,512	$ 205,231	$ 64,529			**$ 556,825**
Total Business Start Up Costs		$ 182,303	$ 199,512	$ 205,231	$ 64,529			**$ 651,575**
Operational Infrastructure								
12 **Operation Staffing including Fringe**		$ 43,184	$ 23,348	$ 41,112	$ 38,582	$ 36,466	$ 36,933	**$ 219,625**
13 **Other Operational Expenses**		$ 39,000		$ -	$ -	$ -	$ -	**$ 39,000**
Total Operational Infrastructure		$ 82,184	$ 23,348	$ 41,112	$ 38,582	$ 36,466	$ 36,933	**$ 258,625**
14 **Indirect Cost/Administrative Overhead Rate**	12.5%	$ 35,161	$ 11,610	$ 6,685	$ 6,173	$ 5,908	$ 5,654	**$ 71,191**
TOTAL INVESTMENTS		**$ 450,000**	**$ 258,000**	**$ 265,396**	**$ 120,084**	**$ 53,174**	**$ 50,887**	**$ 1,197,540**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Expensed in overhead rate.

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Ehana -Initial Purchase	$ 125,000.00

	A	B	C	D	E	F	G
34							
35							
36							
37							
38							
39	**Total Development and Adaptation of**						
40	**EHR and Care Management System**						
41	**(Infrastructure Budget Line 2)**	$ 125,000.00					
42							
43	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the***						
44	***CP's contract and how the costs were determined:***						
45							
46	The cost of the implementation of the care management platform was determined based on a formal quote received by						
47	the platform provider, eHana. The total cost of the platform is $200,000 and is being split between The Bridge of						
48	Central Massachusetts, Inc. (Lead agency for Behavioral Health Community Partner contract) and Alternatives						
49	Unlimited, Inc. (Lead agency for LTSS Community Partner contract).						
50							
51							
52							
53							
54							
55							
56							
57							
58	**Row 3 - Technology for Service Delivery**						
59	**Description of Expense**	**Cost**					
60	Purchase of Computer and Laptops	$ 15,934.00					
61							
62							
63							
64							
65							
66	**Total Technology for Service Delivery**						

	A	B	C	D	E	F	G
67	**(Infrastructure Budget Line 3)**	**$ 15,934.00**					

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Each employee will be provided with a computer package customized to the needs of the positions: .
Updated costs:
Care Coordinators (6), because they will spend considerable time in the field, will receive a laptop ($1,226), docking station ($150), keyboard/mouse ($20), dell briefcase ($41) , Office license and symantex drive encrytion ($539). The unit cost is $2,152. Total: $12,912. These prices are based on an updated quote from Dell.
Sr. Clinical Care Mgr. and Care Manager will receive a desktop workstation ($965), monitor ($176), mouse/keyboard ($20), Office license ($350) . Total unit cost $1,511. Total: 3,022.
Total preliminary period cost $15,934

Row 4 - Other Technology Expenses

Description of Expense	**Cost**
Configure laptops and stations 50 hrs.	$ 1,418.00
Total Other Technology Expenses (Infrastructure Budget Line 4)	**$ 1,418.00**

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

To configure laptops and stations, approximately 50hours at $28.36/hour including tax and .

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate	24.9%	Total Fringe	$ -
			Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 6 - Recruitment Expenses

Description of Expense	Cost
Staff Recruitment	
- On line advertising	$ 3,000.00
- Newspapers	$ 3,000.00
- Radio / other outlets	$ 1,000.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 7,000.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

This is based on a total Partnership Recruitment cost of $9,000 of which the LTTS program will contribute $7,000.

We will utilize a multi-faceted approach to recruitment. In its recruitment efforts, in addition to promoting from within our organizations. The Partners will utilize local papers, college career resource centers, internet sources, career fairs, trade publications, Recovery Learning Communities, and employee referrals to source and hire qualified applicants for positions. Hosting internal career fairs for current employees to learn about opportunities for promotion, career paths, training offerings, and educational assistance may also be utilized. This event serves as both

a recruitment and retention activity.

New and open positions will also be posted on the agency websites, CareerBuilder, Job Target, FaceBook, Indeed, Linked In, Monster, local college career boards, College Central, and the Recovery Learning Community. In addition, advertisements will be placed in area newspapers. The Partnership will employ staff of diverse backgrounds to ensure culturally sensitive and linguistically competent services for all individuals served. Our recruitment efforts will include advertisements in minority publications such as (including El Mundo, Vocero Hispano, and the Worcester African Monitor News) We also work with minority and diversity groups in local colleges and universities, and we participate in the Worcester Chamber of Commerce Diversity Committee.

Row 7 - Training Expenses

Description of Expense	Cost
Conferences	$ 1,000.00
Total Training Expenses (Infrastructure Budget Line 7)	**$ 1,000.00**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Funds are estimated for meetings and conferences to orient 8 new LTSS staff plus shared staff.

Row 8 - Retention Expenses

Description of Expense	Cost

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Business Start Up Costs - Prep Budget Period

Row 9 - Office Equipment

Description of Expense	Cost
Equipment ,(Phone Equipment, ETC	$ 2,500.00
Phone system and wiring	$ 28,650.00
Total Office Equipment (Infrastructure Budget Line 9)	**$ 31,150.00**

Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were determined:

Office equipment for 10 ncludes storage cabinets, ($336 ea), faxes machines ($100 ea), printer/copiers ($300 ea), etc., and are calculated based on $250 per employee.
Cost of purchasing 2 phone system s that will accommodate the L primary TSS / BH Community Partnership Program sites . This includes the cost of VOIP Allworx phone server hardware/software ($4,000 ea.), 4 year warranty ($1,800 ea.), Verge phones ($275 ea.), GB POE Procurve Switch ($2,500 ea.), cables and misc. Total $22,650 and $6,000 for

Row 10 - Office Furniture

Description of Expense	Cost
Furniture	$ 17,600.00
Total Office Furniture (Infrastructure Budget Line 10)	**$ 17,600.00**

Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:

The cost of office furniture estimated at $1600 per employee, to include desk ($608,) desk chairs ($122), side chairs ($71 ea.), 2 drawer files ($126), plus misc. items per person. Also, portion of conference tables ($203 ea) chairs ($105 ea), bulletin boards, shredders, wastebaskets, bulletin boards, etc. The cost included in the infrastructure start up is initial start-up staff. Additional furniture will be purchased in year 1.

We anticipate purchasing furniture for 11 staff so that as staff are hired we will have furniture for them. Additional furniture for anticipated additional staff will be purchased in year 1.

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Community Partnership Director	$ 95,000.00	0.5	6	$ 23,750
Quality Manager	$ 65,000.00	0.5	4	$ 10,833
				$ -
				$ -
				$ -
	Total Salary	1		$ 34,583.00
	Fringe rate	24.9%	Total Fringe	$ 8,601.00
			Total Program Staffing including Fringe (Infrastructure Budget Line 12)	**$ 43,184.00**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

The Director, Director of Quality are shared expenses throughout the Community Partnership Program . These three position will oversee the both the Behavioral Health and the LTSS programs . *Their role will be to oversee the delivery and quality of services, build and or enhance relationship with ACO, partner agencies and material subcontractors*

Director of Quality and Compliance - CP quality activities, analysis, and reporting of indicators and outcomes for the BH

Director of Quality and Compliance - Quality activities, analysis, and reporting of indicators and outcomes for the BH CP program as required by the CP contract.
Community Partnership Director - Oversee the development of the CCHP/BH program and all its components, including overseeing staff hiring. Build relationships with agencies and provide support to the BH program and ensure the CP is meeting contract obligations.

Row 13 - Other Operational Expenses

Description of Expense	Cost
Operational expenses	$ 39,000.00
Total Other Operational Expenses (Infrastructure Budget Line 13)	**$ 39,000.00**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Other operational expenses include: $30,000 Consulting Cost to provide expertise in start up activity such as defining and organizing Partnership Structure, formulating policies with regard to service delivery, best practice and quality.The contract is for a three month period and is for approximately 200 hours @ 150 per hour. Consultant Responsibilities*:*
Lead CCHP Steering Team: a. oversight of the implementation, approval of material decisions related to implementation of the community partners . b. defining how the community partners will be governed. c. contracting with ACOs and MCOs, and developing MOUs among Affiliated Partners, Lead Agencies and Material Subcontractors. d. conducting and completing Readiness Review. e. executing contracts with EOHHS.
Lead for CCPH Model & Quality Team : a. defining the service models b. developing policies & procedures c. defining all aspects of operations . d. engaging other work groups (ex: HR, Finance) to complete activities.
Legal 9,000 External partnerships: a. represent CCHP with external partners including ACOs, MCOs, EOHHS, b.

Legal 5,000 External partnerships: a. Represent CCHP with external partners including ACOs, MCOs, EOHHS ; b. Interface with legal counsel. Approximatly 45 hrs at $200 per hour. No legal fee are allocated to contacting with EOHHS contracts,

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead	12.5	$ 35,161.00

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

The 12.5% is Alternatives' standard overhead rate covering all administrative functions including payroll, HR, IT, Prroperty Services and senior management.

Community Partner Infrastructure Allocation Worksheet

	Alternatives Unlimited, Inc.						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL FUNDS AVAILABLE	$ 450,000	$ 432,075	$ 528,474	$ 410,959	$ 244,363	$ 112,652	$ 2,178,523
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Alternatives Unlimited Inc.	$ 131,720	$ 7,176	$ 4,403	$ 3,795	$ 3,795	$ 2,827	$ 153,716
Venture Community Services	$ 4,556	$ 4,866	$ 2,985	$ 2,573	$ 2,573	$ 1,917	$ 19,470
LUK Inc.	$ 3,038	$ 3,244	$ 1,990	$ 1,716	$ 1,716	$ 1,278	$ 12,982
The Bridge of Central MA	$ 3,038	$ 3,244	$ 1,990	$ 1,716	$ 1,716	$ 1,278	$ 12,982
							$ -
Total Technology	$ 142,352	$ 18,530	$ 11,368	$ 9,800	$ 9,800	$ 7,300	$ 199,150
Workforce Development							
Alternatives Unlimited Inc.	$ 3,098	$ 1,937	$ 387	$ 387	$ 387	$ 387	$ 6,583
Venture Community Services	$ 2,102	$ 1,313	$ 263	$ 263	$ 263	$ 263	$ 4,467
LUK Inc.	$ 1,400	$ 875	$ 175	$ 175	$ 175	$ 175	$ 2,975
The Bridge of Central MA	$ 1,400	$ 875	$ 175	$ 175	$ 175	$ 175	$ 2,975
					$ -	$ -	$ -
Total Workforce Development	$ 8,000	$ 5,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000	$ 17,000
Business Start Up Costs							
Alternatives Unlimited Inc.	$ 99,689	$ 108,720	$ 134,804	$ 24,993	$ -	$ -	$ 368,206
Venture Community Services	$ 35,406	$ 38,912	$ 30,183	$ 16,944	$ -	$ -	$ 121,445
LUK Inc.	$ 23,604	$ 25,940	$ 20,122	$ 11,296	$ -	$ -	$ 80,962
The Bridge of Central MA	$ 23,604	$ 25,940	$ 20,122	$ 11,296	$ -	$ -	$ 80,962
			$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ 182,303	$ 199,512	$ 205,231	$ 64,529	$ -	$ -	$ 651,575
Operational Infrastructure							
Alternatives Unlimited Inc.	$ 58,206	$ 23,348	$ 41,112	$ 38,582	$ 36,466	$ 36,933	$ 234,647
Venture Community Services	$ 10,276						$ 10,276
LUK Inc.	$ 6,851						$ 6,851
The Bridge of Central MA	$ 6,851						$ 6,851
							$ -
Operational Infrastructure	$ 82,184	$ 23,348	$ 41,112	$ 38,582	$ 36,466	$ 36,933	$ 258,625
TOTAL INVESTMENTS	$ 414,839	$ 246,390	$ 258,711	$ 113,911	$ 47,266	$ 45,233	$ 1,126,350

Costs were allocated to Affiliate Partners based on FTE.
Exceptions to this methodology include:

Technology: The cost of EHANA is being paid by Alternatives and will be use by other partners.

Business Start up : The cost of Phone and Wiring systems allocated to Alternatives.

Operational Infrastructure: Consultant cost were allocated to Alternatives

Community Partner Milestones Report

					Alternatives Unlimited, Inc.							
					PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
Infrastructure Category	**Infrastructure Investment Project**	**Project Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
Technology	Development and Adaptation of E.H.R/Care Management System	Configuration and implementation of CP IT platform	11/01/17	05/30/18	Configuration completed, implementation in progress	User Acceptance Testing completed			CP IT platform ready for Program Go-Live	CP IT platform is operational		
Technology	Development and Adaptation of E.H.R/Care Management System	Training of CP staff on Care Management platform	03/01/18	05/30/18	Training on CP platform in progress	Initial hires engagged in training			CP program staff trained on platform	Staff training complete		
Technology	Technology for Service Delivery	Identify and purchase computer packages for staff	12/01/17	05/31/18	Identify, purchase, and set up CP staff computer packages	Purchasing and set up in progress			Purchasing and set up completed and ready for program Go-Live	Computer systems operational		
Technology												
Workforce Development	Workforce Development Staffing including Fringe	Recruitment and hiring of staff needed for program start-up	11/01/17	05/30/18	Initial hires identified and actively recruiting for remaining positions	Initial hires accepted job offers and are onboarding			CP Program staff in place for Go-Live	Remaining positions for Go-Live accepted job offers and are onboarding		
Workforce Development	Workforce Development Staffing including Fringe	Develop training curriculum	10/01/17	02/01/18	Goal completed	Training curriculum completed and ready for implementation			Curriculum completed	Curriculum completed		
Workforce Development	Workforce Development Staffing including Fringe	Training of staff on CP program curriculum	02/01/18	05/30/18	Training on CP curriculum	CP staff training in progress			CP staff training completed	Staff training completed		
Workforce Development												
Business Start Up Costs	Office Equipment	Purchase office equipment	12/01/17	12/31/18	Goal completed	Equipment purchased			Equipment in place and ready for Go-Live	Equipment functional		
Business Start Up Costs	Office Furniture	Purchase office furniture	12/01/17	12/31/18	Goal completed	Furniture purchased			Furniture in place and ready for Go-Live	Furniture in place		
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Other Operational Expenses	Contract with consultant for CP administration	10/01/17	10/01/17	Goal completed	Consultant working with CP			Consultant working with CP	Consultant working with CP		
Operational Infrastructure	Other Operational Expenses	Office space for CP program	10/01/17	05/01/18	Space / Site identified	Purchase or lease agreements being executed			CP Program site occupied and ready for Go-Live	CP program staff working out of CP program site		
Operational Infrastructure												
Operational Infrastructure												

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Project Manager - BMC	$ 75,000.00	0.8	6	$ 30,000
Care Coordinator 1 - BMC	$ 45,000.00	1	5	$ 18,750
Care Coordinator 1 - BSHC	$ 45,000.00	1	3	$ 11,250
Care Coordinator 1 - CBES	$ 45,000.00	1	3	$ 11,250
Care Coordinator 1 - Ethos	$ 45,000.00	1	3	$ 11,250
Total Salary (Program Budget Line 1)		**4.8**		**$ 82,500**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 82,500.00	31%	$ 25,740
Total Fringe (Program Budget Line 2)			**$ 25,740**

Total Personnel*	**$ 108,240**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

BMC Project Manager - The TBN Project Manager will dedicate all of her/his budgeted effort during the Prep Period towards training and preparation for project implementation on Day 1 of Year 1 of the project. S/he will be trained to provide trauma-informed care and brief motivational interviewing. S/he will devote their effort to workforce development during the Prep Period and will supervise the BMC Care Coordinators, oversee administrative responsibilities and support the Project Director.

BMC (Lead) Care Coordinator 1 - The TBN Lead Care Coordinator (CC1) will dedicate all of her/his budgeted effort during the prep period towards training and preparations for project implementation on Day 1 of Year 1 of the project. S/he will receive appropriate training to provide care coordination and linkage to LTSS for enrollees. Each Coordinator will be trained to deliver culturally and economically responsive care, and the CC1 will utilize his/her skills and training to help train the other BMC Care Coordinators as they join the project.

BSHC Care Coordinator - The TBN BSHC Care Coordinator will dedicate all of her/his budgeted effort during the Prep Period towards training and preparation for project implementation on Day 1 of Year 1 of the project. The TBN Care Coordinator will provide care coordination and linkage to LTSS for enrollees. The Coordinators will be trained to deliver culturally appropriate and economically responsive care. The BSHC Care Coordinators will be supervised day-to-day by the BSHC Project Manager, but will also be responsible for ensuring the accurate and timely reporting of project related activities to the BMC Project Manager and Lead Care Coordinator.

CBES Care Coordinator - The TBN CBES Care Coordinator will dedicate all of her/his budgeted effort during the prep period towards training and preparation for project implementation on Day 1 of Year 1 of the project. S/he will provide care coordination and linkage to LTSS for enrollees. The Coordinators will be trained to deliver culturally appropriate and economically responsive care. The CBES Care Coordinators will be supervised day-to-day by the CBES Project Manager, but will also be responsible for ensuring the accurate and timely reporting of project related activities to the BMC Project Manager and Lead Care Coordinator.

Ethos Care Coordinator - The TBN Ethos Care Coordinator will dedicate all of her/his budgeted effort during the prep period towards training and preparation for project implementation on Day 1 of Year 1 of the project. S/he will provide care coordination and linkage to LTSS for enrollees. The Coordinators will be trained to deliver culturally appropriate and economically responsive care. The Ethos Care Coordinators will be supervised day-to-day by the Ethos Project Manager, but will also be responsible for ensuring the accurate and timely reporting of project related activities to the BMC Project Manager and Lead Care Coordinator.

3% cost of living increases for staff beginning in Year 2

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Not budgeted in the Project Budget for the Prep Period			
Total Training and Professional Development (Program Budget Line 3)			

Provide a description of each Training and Professional Development line item included in the table abovNot budgeted in the Project Budget for the Prep Period:

Not budgeted in the Project Budget for the Prep Period

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
N/A for this Period				
			Total Mileage	

Travel Expense Description	Cost
Total Mileage	$ -
Parking and tolls	
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ -**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

N/A for this Period

Row 5 - Equipment

Description of Equipment	Unit Cost	#units or FTEs	Cost
N/A for this Period			
Total Equipment (Program Budget Line 5)			

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

N/A for this Period

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
N/A for this Period			
Total Supplies (Program Budget Line 6)			

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

N/A for this Period

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

ACT.md and **Verizon Wireless-** Although not included in the Budget Prep Period, in subsequent budget periods (Years 1-5) we will include yearly ACT.md and Verizon user fees/subscription costs here.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
N/A for this Period			
Total Software Licensing (Program Budget Line 8)			

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

N/A for this Period

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
N/A for this Period			
Total Telecommunications (Program Budget Line 9)			

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

N/A for this Period

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent- N/A			$ -
Utilities - N/A			$ -
Repair and Maintenance - N/A			$ -
Total Occupancy (Program Budget Line 10)			

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

Row 11 - Other

Other Direct Expense Description	Cost
Affiliated Partners CA Fees	$9,300
Total Other Direct Costs (Program Budget Line 11)	**$ 9,300.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

We have included Contract Administrative costs for our three affiliated partners in their subcontracts at the rate of 15% of

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead	**15.00%**	**$17,631**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

	A	B	C	D	E	F
229	In addition to the costs detailed above, BMC is requesting indirect costs to cover the administration of the contract. Indirect costs are calculated at 15% of total costs for this project and are a vital part of infrastructure building. Costs for Prep are calculated at $17,631					
230						
231						
232						

Community Partner Program Budget Report

				BAP				
Program Revenue		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
Estimated Enrollees- Start of Period (All Enrollees)			143	1,001	1,001	1,001	1,001	
Estimated Enrollees - End of Period (All Enrollees)			1,001	1,001	1,001	1,001	1,001	
Estimated Enrollees - Monthly Average			572	1,001	1,001	1,001	1,001	
Total Estimated Program Revenue			**$ 320,320**	**$ 960,960**	**$ 960,960**	**$ 960,960**	**$ 960,960**	**$ 4,164,160**
At- Risk Withhold Rate				0%	0%	0%	0%	
Withhold funds				$ -	$ -	$ -	$ -	$ -
Revenue for Operations			$ 320,320	$ 960,960	$ 960,960	$ 960,960	$ 960,960	$ 4,164,160
	Program Expenses	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
1	Salary	$ 82,500	$ 275,070	$ 633,933	$ 714,685	$ 742,154	$ 740,944	$ 3,189,286.00
2	**Fringe**	$ 25,740	$ 85,832	$ 197,788	$ 222,981	$ 231,553	$ 231,176	$ 995,070.00
	Total Personnel Costs	$ 108,240	$ 360,902	$ 831,721	$ 937,666	$ 973,707	$ 972,120	$ 4,184,356
3	**Training & Professional Development**	o	$ -	$ -	$ -	$ -	$ -	$ -
4	**Travel**	$ -	$ 9,150	$ 39,120	$ 39,120	$ 39,120	$ 39,120	$ 165,630
5	**Equipment**	o	$ -	$ -	$ -	$ -	$ -	$ -
6	**Supplies**	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	**Contract Services** (consulting, professional)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	**Software licensing**	$ -	$ 10,950	$ 21,900	$ 21,900	$ 21,900	$ 21,900	$ 98,550
9	**Telecommunications**	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	**Occupancy** (rent, utilities, maintenance)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	**Other** (Affiliated Patrners contract administration Fees)	$ 9,300	$ 36,986	$ 67,373	$ 69,288	$ 71,261	$ 73,293	$ 327,501
	Total Direct Costs	$ 117,540	$ 417,988	$ 960,114	$ 1,067,974	$ 1,105,988	$ 1,106,433	$ 4,776,037
12	**Indirect Cost/Administrative Overhead** **15.0%**	**$ 17,631**	**$ 62,698**	**$ 144,017**	**$ 160,196**	**$ 165,898**	**$ 165,965**	$ 716,406
	TOTAL EXPENSES	$ 135,171	$ 480,686	$ 1,104,131	$ 1,228,170	$ 1,271,886	$ 1,272,398	$ 5,492,443
	Surplus/Shortfall	*$ (135,171)*	*$ (160,366)*	*$ (143,171)*	*$ (267,210)*	*$ (310,926)*	*$ (311,438)*	*$ (1,328,283)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Infrastructure Budget Report

			BAP					
	Infrastructure Investment Funding		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
	PMPM Infrastructure Rate			$ 75.00	$ 49.72	$ 43.28	$ 36.40	$ 29.34	
	Engaged Enrollees			1,001	1,001	1,001	1,001	1,001	
	Estimated Infrastructure Funds			$ 525,525	$ 597,237	$ 519,879	$ 437,237	$ 352,432	**$ 2,432,310**
	At- Risk Withhold Rate				25%	44%	63%	81%	
	Withhold				$ 149,309	$ 228,747	$ 275,459	$ 285,470	**$ 938,985**
	TOTAL MAXIMUM FUNDS AVAILABLE		$ 450,000	$ 525,525	$ 447,927	$ 291,132	$ 161,778	$ 66,962	**$ 1,943,325**
	Infrastructure Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
	Technology								
1	**IT Staffing including Fringe**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
2	**Development Adaptation of EHR and/or Care Management System**		$ 77,000	$ -	$ -	$ -	$ -	$ -	**$ 77,000**
3	**Technology for Service Delivery**		$ 27,200	$ -	$ -	$ -	$ -	$ -	**$ 27,200**
4	**Other Technology Expenses**		$ 5,800	$ -	$ -	$ -	$ -	$ -	**$ 5,800**
	Total Technology		$ 110,000	$ -	$ -	$ -	$ -	$ -	**$ 110,000**
	Workforce Development								
5	**Workforce Development staffing including Fringe**		$ 44,114	$ 185,150	$ 105,568	$ 46,100	$ 39,569	$ 32,605	**$ 453,106**
6	**Recruitment Expenses**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
7	**Training Expenses**		$ 20,000	$ -	$ -	$ -	$ -	$ -	**$ 20,000**
8	**Retention Expenses**		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Workforce Development		$ 64,114	$ 185,150	$ 105,568	$ 46,100	$ 39,569	$ 32,605	**$ 473,106**
	Business Start Up Costs								
9	**Office Equipment (PBP & BP1 only)**			$ -					**$ -**
10	**Office Furniture (PBP & BP1 only)**			$ -					**$ -**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**		$ 135,171	$ 160,366	$ 143,171	$ 267,210			**$ 705,918**
	Total Business Start Up Costs		$ 135,171	$ 160,366	$ 143,171	$ 267,210	$ -	$ -	**$ 705,918**
	Operational Infrastructure								
12	**Operation Staffing including Fringe**		$ 69,164	$ 66,557	$ 109,216	$ 88,017	$ 84,353	$ 68,476	**$ 485,783**
13	**Other Operational Expenses**		$ 30,000	$ 36,000	$ 46,500	$ 34,000	$ 22,500	$ 9,000	**$ 178,000**
	Total Operational Infrastructure		$ 99,164	$ 102,557	$ 155,716	$ 122,017	$ 106,853	$ 77,476	**$ 663,783**
14	**Indirect Cost/Administrative Overhead Rate**	15.0%	$ 40,992	$ 43,156	$ 39,193	$ 25,218	$ 21,963	$ 16,512	**$ 187,033**
	TOTAL INVESTMENTS		**$ 449,441**	**$ 491,229**	**$ 443,648**	**$ 460,545**	**$ 168,385**	**$ 126,593**	**$ 2,139,841**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
	$ -	0		$ -
	$ -	0		$ -
	$ -	0		$ -
	$ -	0		$ -
	$ -	0		$ -
	$ -	0		$ -
	$ -	0		$ -
	$ -	0		$ -
	$ -	0		$ -
	Total Salary	0		$ -
	Fringe rate	31.2%	Total Fringe	$ -
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
ACT.md Cloud-Based Case Management	$77,000
Total Development and Adaptation of EHR and Care Management System (Infrastructure Budget Line 2)	$77,000

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

We will contract with ACT.md for use of their electronic cloud-based platform. ACT.md provides a HIPAA-compliant, cloud-based platform designed for team-based care. ACT.md connects care teams, facilitates communication and collaboration, and drives coordinated action. For this project, ACT.md is expected to support the following program initiatives: 1)serve as the unifying technology for multi-disciplinary and multi-agency care coordination; 2) capture enrollee information and contact information for care team members, including PCPs and ACO/MCO; 3) develop and execute patient-centered, goal-oriented care plans; 4) administer, record and export enrollee assessment data; 5) create templates and suggested workflows and provide visibility into the care process; and 6) report on number of engaged enrollees, care plans created, and referrals for LTSS community support services. There will be a one-time Implementation Fee which include fees for: Project Management and consulting; Eligibility file upload and data mapping; One custom care plan template; Six custom workflows; Three Custom Assessments (or discrete data field creation); Two Days Centralized Training for Care Team Users; One Day Administrative User Training; Technical Integration Fees; Event Notification Service Integration; and Health Information Exchange Integration. The total cost for the one-time implementation fee is $77,000.

Row 3 - Technology for Service Delivery

Description of Expense	Cost
16 Lenovo ThinkPad P51 Mobile Workstations	$ 24,000.00
Symantec (or an equivalent) Encryption Software	$ 3,200.00

	A	B	C	D	E	F	G
61	**Total Technology for Service Delivery**	**$ 27,200.00**					
62	**(Infrastructure Budget Line 3)**						

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

We are budgeting funds to purchase 16 Lenovo ThinkPad P51 Mobile Workstations for program staff at $1,500 each. We are budgeting to also purchase Symantec (or an equivalent) encryption software for each Think Pad at $200 each. These project-specific workstations will be vital to capturing and maintaining data security. The total cost for laptops is $1,500 x 16 = $24,000. The total cost of the software is $200 x 16 = $3,200. Total combined cost = $27,200.

Laptop allocation is as follows:

BMC
C0-Director 1 = 1
Project Director = 1
Project Manager = 1
Care Coordinators (4) = 4

BSHC
Project Manager = 1
Care Coordinators (2) = 2

CBES
Project Manager = 1
Care Coordinators (2) = 2

Ethos
Project Manager = 1
Care Coordinators (2) = 2

Row 4 - Other Technology Expenses

Description of Expense	Cost
10 IPads	$4,150
10 Data plans	$1,650
Total Other Technology Expenses (Infrastructure Budget Line 4)	**$ 5,800.00**

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

We plan to provide our 10 care coordinators with IPads to allow them to develop, review and update the online ACT.md HIPAA secure care plans with our Enrollees in their homes or other community settings. Each IPad will have a monthly wireless data plan through Verizon Wireless. Data usage will be monitored by the Project Director.

IPad allocation is as follows:

BMC
Care Coordinators (4) = 4

BSHC
Care Coordinators (2) = 2

CBES
Care Coordinators (2) = 2

Ethos
Care Coordinators (2) = 2

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Co-Director 2 - BMC	$ 177,055.00	0.12	6	$ 10,623
Project Director - BMC	$ 110,400.00	0.5	5	$ 23,000
	$ -	0		$ -
	Total Salary	0.62		$ 33,623
	Fringe rate	31.2%	Total Fringe	$ 10,490
Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)				**$ 44,114**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Workforce Development and Staffing

Co-Director 2 - She will be responsible for ensuring that the social determinants of health are mitigated for Enrollees and will work with staff to help them identify and remove barriers to care. She is a national expert in examining how the social determinants of health impact healthcare access and treatment. During the Prep Period she will be dedicated to helping design the training curriculum and workforce development. This essential work will provide a foundation on which we will build an unmatched and self-sustaining program. Co-Director 2 will remain involved with the project in an advisory role in subsequent years, but will draw salary support from either the Infrastructure or Program Budget.

BMC Project Director - She will be responsible for overseeing all aspects of the project—hiring, training, and supporting personnel and reporting up to the Co-Directors and Governing Body. She will also work with the Consumer Advisory Board throughout the project to make sure they are abreast of all activities and integrate their input into BAP. Because the Project Director will be focused on training, workforce development and operations we have allocated 100% of her budgeted effort to the Infrastructure Budget in the Prep Period, with 50% devoted to workforce development and staffing, and 50% devoted to operations and administration.. However, in subsequent years percentages of the Project Director's effort will be accounted for in both the Infrastructure and Project Budgets.

Row 6 - Recruitment Expenses

Description of Expense	Cost
N/A	
Total Recruitment Expenses (Infrastructure Budget Line 6)	

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

N/A this Period

Row 7 - Training Expenses

Description of Expense	Cost
Workforce Training	$20,000.00
Total Training Expenses	**$20,000**

	A	B
187	**(Infrastructure Budget Line 7)**	~~$20,000~~

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

BAP plans to develop a standardized mandatory training curriculum for all care coordinators. The Project Director is consulting with Co-Director 2 and the Executive Director of Boston Senior Home Care in the creation of this curriculum. We anticipate that we will need to contract with external training providers for the development and/or delivery of many of the planned training sessions. Once the curriculum is developed, the Project Director with members of the BMC team will be responsible for implementing the training curriculum for all BAP staff.

Based on a calculation of 15 separate trainings at an estimated cost of $130/training for each of the 10 care coordinators, we have budgeted $20,000 in the Prep Period for these contracted trainings. If the budget allows we would also include our affiliated partners four project manager.

Training topics may include:

1. Overview of LTSS CP Program and Approach - To be developed jointly by BMC and the ASAPs with input from EOHHS.
2. Overview of LTSS Populations: including, behavioral and cognitive impairments, physical disabilities, autism and ID/DD. Also definitions, diagnosis criteria, associated entitlements, cultural implications, costs associated with condition, etc.
3. LTSS Care Plan Development Processes and Implementation, including Care Team development and principles of Self Determination and Community First
4. Orientation to Care Coordination and Information Technology System
5. Overview of MassHealth State Plan: LTSS services and eligibility criteria, choice counseling, person centered planning
6. Overview of Independent Living: movement and recovery principles, accessibility and accommodations
7. Orientation to roles and responsibilities of state, community, municipal agencies and organizations
8. Orientation to Local Resources and Community Mapping Techniques
9. Enrollee Rights and Protections: human, legal, civil rights: community, LTSS, SDH services, etc.
10. Enrollee Engagement Strategies: motivational interviewing, stage of change and harm reduction techniques
11. Orientation to Health Care Integration Strategies: population health management, health and wellness Principles and Coaching tools
12. Orientation to National Research and Advances
13. Empowerment and Self-advocacy Techniques
14. Cultural Competency

Row 8 - Retention Expenses

Description of Expense	Cost
N/A	
Total Retention Expenses (Infrastructure Budget Line 8)	

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

N/A this Period

Community Partner Infrastructure Budget Report - Business Start Up Costs - Prep Budget Period

Row 9 - Office Equipment

Description of Expense	Cost
N/A	
Total Office Equipment (Infrastructure Budget Line 9)	

Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were determined:

N/A this Period

Row 10 - Office Furniture

Description of Expense	Cost
N/A	
Total Office Furniture (Infrastructure Budget Line 10)	

Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:

N/A this Period

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Co-Director 1 - BMC	$ 175,849.00	0.144	5	$ 10,550.94
Project Administrator - BMC	$ 94,416.00	0.12	6	$ 5,664.96
Project Manager - BSHC	$ 75,000.00	0.12	6	$ 4,500.00
Project Manager - CBES	$ 75,000.00	0.12	6	$ 4,500.00
Project Manager - Ethos	$ 75,000.00	0.12	6	$ 4,500.00
Project Director - BMC	$ 110,400.00	0.5	5	$ 23,000.00
				$ -
				$ -
				$ -
	Total Salary	1.124		$ 52,715.90
	Fringe rate	31.2%	Total Fringe	$ 16,447.36
			Total Program Staffing including Fringe	$ 69,163.26

	A	B	C	D	E	F	G
304				**(Infrastructure Budget Line 12)**	$ 69,163.20		

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Operations Staffing

Co-Director 1 - He will oversee the project in conjunction with Co-Director 2. He has extensive experience coordinating large projects that deliver LTSS to vulnerable populations. Co-Director 1 will oversee all operational infrastructure and work to enhance performance management in the Prep Period, helping to ensure the program is self-sustaining beyond the contract period. (*In subsequent years, percentages of the Co-Director's effort will be accounted for in both the Infrastructure and Program Budgets*.)

Project Administrator -He will ensure all aspects of the project are in compliance with state regulations. He is an experienced administrator and will track enrollees and handle all reporting. The Project Administrator will focus entirely on business startup and infrastructure building and therefore is not budgeted on the program budget. BMC has a federally approved indirect cost rate of 28%. We chose to use the MassHealth allowable rate of 15%, cutting indirect costs in half, and allowing us to devote more funding to direct project costs to the benefit of our targeted consumers. Therefore we are requesting to include our staffing-related administrative costs in our direct costs, as is generally allowed for federally funded projects.

BSHC Project Manager - The TBN BSHC Project Manager will devote their effort to infrastructure and workforce development during the Prep Period. S/he will provide day-to-day supervision to the BSHC Care Coordinators focused on ensuring all activities of the BSHC Care Coordinators are appropriately aligned with the mission and goals of the program. S/he will manage administrative responsibilities for BSHC and will report to the BMC Project Manager for project related matters.

CBES Project Manager - The TBN CBES Project Manager will devote their effort to infrastructure and workforce development during the Prep Period. S/he will provide day-to-day supervision to the CBES Care Coordinators focused on ensuring all activities of the CBES Care Coordinators are appropriately aligned with the mission and goals of the program. S/he will manage administrative responsibilities for CBES and will report to the BMC Project Manager for project related matters.

Ethos - Project Manager - The TBN Ethos Project Manager will devote their effort to infrastructure and workforce development during the Prep Period. S/he will provide day-to-day supervision to the Ethos Care Coordinators focused on ensuring all activities of the Ethos Care Coordinators are appropriately aligned with the mission and goals of the program. S/he will manage administrative responsibilities for Ethos and will report to the BMC Project Manager for project related matters.

BMC Project Director - She will be responsible for overseeing all aspects of the project—hiring, training, and supporting personnel and reporting up to the Co-Directors and Governing Body. She will also work with the Consumer Advisory Board throughout the project to make sure they are abreast of all activities and integrate their input into BAP. Because the Project Director will be focused on training, workforce development and operations we have allocated 100% of her budgeted effort to the Infrastructure Budget in the Prep Period, with 50% devoted to workforce development and staffing, and 50% devoted to operations and administration.. However, in subsequent years percentages of the Project Director's effort will be accounted for in both the Infrastructure and Project Budgets.

Row 13 - Other Operational Expenses

Description of Expense	Cost
Legal	$ 4,000.00
Printing	$ 4,500.00
Promotional/Collatarel Materials	$ 4,000.00
Translation Services	$ 7,500.00
Marketing/Advertising	$ 4,000.00
Statistician	$ 6,000.00
Total Other Operational Expenses (Infrastructure Budget Line 13)	**$30,000.00**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Evaluation/Statistician - We have budgeted to contract with a **statistician** to help evaluate our project. The statistician will allow us to examine the effectiveness of our program. We will iterate our strategic plan based on feedback and effectiveness. The statistician has a rate of $150/hour and will devote 40 hours in the Prep Period for a total of $6,000. During the PBP s/he to begin to build the models and become familiar with the data components involved for the work we had outlined in the original Program Plan for this role

BMC will work with EOHHS and its ACO/MCO partners to determine the return on investment of the BAP, which holds the key to its sustainability. This will be an iterative process in which the impact of the BAP on utilization and the cost of care is routinely reviewed

sustainability. This will be an iterative process in which the impact of the BAP on utilization and the cost of care is routinely reviewed by the BAP Management Team. To this end, we have budgeted for the use of DSRIP funds in support of a statistician from the Boston University School of Public who will examine utilization, cost and DxCG risk score (if available from the ACO/MCO), overall and by age, gender, LTSS population type, services utilization, and other variables of interest. We anticipate that the minimum 1,000 Enrollees served by the BAP will adequately power analyses to determine if significant effects are found for most, if not all of these variables

A number of research questions will be examined. Overall, do LTSS, social services, and/or Flexible Services bring down the total cost of care, and does this amount cover the $80 PMPM payment used to cover LTSS CP costs? Does a reduction in DxCG risk score moderate the reductions in cost? Which services are most effective in containing the cost of care, for which Enrollees, and where are the greatest savings evident? How long does it take for LTSS to achieve their greatest impact? What is the optimum frequency and intensity of Care Coordinator services?

An annual formative evaluation, to be reviewed by the BAP Management Team and Quality Committee in collaboration with ACO/MCOs and EOHHS, will guide efforts to improve the overall quality of the program by strengthening the use of the most effective LTSS services and supports and focusing the time and attention of the Care Coordinators on Enrollees at highest risk. Summative evaluation will assess the overall effectiveness of the program for various populations, as well as its return on investment.

ANOVA, multiple regressions and time-series analysis will be used in the analyses.

Legal - We are requesting $4,000 to cover the costs of possible Legal Fees related to contracting with ACO and MCOs during the Prep Period. Costs will ensure we are able to meet all contractual requirements.

EXTERNAL COMMUNICATION AND MARKETING RELATED COSTS

1. Promotional/Collateral Materials - We have budgeted $4,000 to cover the costs of designing and creating promotional and Enrollee focused collateral materials for the project. These materials will explain the purpose of BAP, it's expertise, and the benefits of LTSS for targeted Enrollees.

2. Translation Services - We have budgeted $7,500 for the cost of translating Enrollee focused print and electronic project materials into languages commonly spoken by patients at the participating sites. At BMC these languages include Spanish, Portuguese, Haitian Creole, Arabic, Chinese and Vietnamese. Understanding that costs will vary for each language, we are estimating an average cost of $30/hour and have budgeted for 250 hours = $7,500

3. Printing - We are requesting $4,500 to cover the costs of printing patient materials for Targeted Enrollees in multiple languages. Printing linguistically appropriate, culturally responsive materials for all potential Enrollees will allow us to meet the requirements of the contract.

4. Marketing/Advertising - We have budgeted $4,000 to cover the costs of marketing/advertising the availability of LTSS in the communities served by BAP.

Affiliated Partners Infrastructure Support - Although not included in the Prep Period, in subsequent budget periods we will include

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**15.00%**	**$40,992**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

In addition to the costs detailed above, BMC is requesting indirect costs to cover the administration of the contract. Indirect costs are calculated at 15% of total costs for this project and are a vital part of infrastructure building.
Costs for Prep are calculated at $40,992.

	A	B	C	D	E	F	G
422							
423							
424							
425							
426							
427							
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Community Partner Infrastructure Allocation Worksheet

	Insert Contractor Name Here						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL FUNDS AVAILABLE	$ 450,000	$ 525,525	$ 447,927	$ 291,132	$ 161,778	$ 66,962	$ 1,943,325
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
BMC	$ 108,000	$ -	$ -	$ -	$ -	$ -	$ 108,000
BSHC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CBES	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Ethos	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ 110,000	$ -	$ -	$ -	$ -	$ -	$ 110,000
Workforce Development							$ -
BMC (Prep Period includes $20,000 trainir	$ 64,114	$ 185,150	$ 105,568	$ 46,100	$ 39,569	$ 32,605	$ 473,106
BSHC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CBES	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Ethos	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ 64,114	$ 185,150	$ 105,568	$ 46,100	$ 39,569	$ 32,605	$ 473,106
Business Start Up Costs							$ -
BMC	$ 81,591	$ 160,366	$ 143,171	$ 267,210	$ -	$ -	$ 652,338
BSHC	$ 17,860	$ -	$ -	$ -	$ -	$ -	$ 17,860
CBES	$ 17,860	$ -	$ -	$ -	$ -	$ -	$ 17,860
Ethos	$ 17,860	$ -	$ -	$ -	$ -	$ -	$ 17,860
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ 135,171	$ 160,366	$ 143,171	$ 267,210	$ -	$ -	$ 705,918
Operational Infrastructure							$ -
BMC	$81,452	$ 72,557	$ 140,716	$ 107,017	$ 99,353	$ 74,476	$ 575,571
BSHC	$ 5,904	$ 10,000	$ 5,000	$ 5,000	$ 2,500	$ 1,000	$ 29,404
CBES	$ 5,904	$ 10,000	$ 5,000	$ 5,000	$ 2,500	$ 1,000	$ 29,404
Ethos	$ 5,904	$ 10,000	$ 5,000	$ 5,000	$ 2,500	$ 1,000	$ 29,404
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ 99,164	$ 102,557	$ 155,716	$ 122,017	$ 106,853	$ 77,476	$ 663,783
TOTAL INVESTMENTS	$ 408,449	$ 448,073	$ 404,455	$ 435,327	$ 146,422	$ 110,081	$ 1,952,807

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Development and Adaptation of E.H.R/Care Management System	Complete design of ACT.md Care Planning and Management Information System (CPMIS)	12/01/17	04/30/18								
Technology	Other Technology Investments	Pilot test, refine, and implement CPMIS	03/01/18	05/31/18								
Technology	Technology for Service Delivery	Purchase laptops for project staff	12/01/17	12/31/18								
Technology												
Workforce Development	Workforce Development Staffing including Fringe	Recruit and hire full-time Project Manager	12/01/17	01/31/18								
Workforce Development	Workforce Development Staffing including Fringe	Recruit and hire four full-time Care Coordinators	12/01/17	01/31/18								
Workforce Development	Training Expenses	Complete training of new project staff	01/31/18	05/31/18								
Workforce Development												
Business Start Up Costs	Ramp-up Costs	Create printed materials for marketing materials, information packets, etc. and translate	03/31/18	05/31/18								
Business Start Up Costs	Ramp-up Costs	Execute Contracts with ACOs/MCOs	12/01/17	03/30/18								
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Operation Staffing including Fringe	Complete protocols for Qualifying Activities	12/01/17	04/30/18								
Operational Infrastructure	Operation Staffing including Fringe	Complete Documented Processes in collaboration with EOHHS and ACO/MCO partners	12/01/17	04/15/18								
Operational Infrastructure	Operation Staffing including Fringe	Develop methods of collaboration with state agencies providing LTSS CP supports	12/01/17	04/30/18								
Operational Infrastructure	Other Operational Expenses	Assemble Provider Directory	12/01/17	05/31/18								

Revised DSRIP Participation Plan for Boston Allied Partners

A. Executive Summary

1. Goals, Challenges and Solutions

Goals. Boston Allied Partners (BAP) for Community-based Services and Supports has designed its DSRIP Participation Plan to achieve the following goals: 1) To standardize and streamline the processes of assessment, care planning and delivery of LTSS, leveraging our existing systems and working in collaboration with the ACOs and MCOs contracting with us; 2) To improve the quality of care through comprehensive assessment and matching of enrollees to best evidence-based services and supports, while optimizing enrollee choice; 3) To coordinate the delivery of fully integrated services for a minimum of 1,000 Boston-based LTSS CP Enrollees; 4) To foster integration of services and supports across domains and systems of care; 6) To participate actively and meaningfully on the Enrollee's care team; 6) To strive continuously to improve the quality of CP services; and 7) To execute the LTSS CP contract in an efficient, effective manner.

Challenges. Our DSRIP Participation Plan is designed to anticipate and prevent most operational, financial or compliance-related challenges. At the same time, we know from experience that any new organization—especially one forging new pathways for integrating, coordinating, and monitoring the quality of care for complex populations—will face unexpected challenges. There are often unexpected delays in achieving milestones for program design and development and/or hiring and training of project staff. To avoid such a scenario, the BAP initiated weekly meetings in September and we plan to generate draft policies, procedures and templates for assessment, care planning, Qualifying Activities and Documented Processes before the end of the year. We have also begun to bring ACT.md on board and to meet with ACOs.

By being proactive, we expect to "hit the ground running" when our contract with EOHHS is executed in December 2017, having jumpstarted achievement of many of the milestones in our Prep Period Budget Report. This in turn will allow us to focus on other critical tasks during the Prep Budget Period, including the development and testing of the CPMIS; convening of our Community Advisory Board, Governing Body, and Quality Management Committee; and completion of deliverables including our Grievance Procedure, Conflict Resolution Procedure and Quality Improvement Plan. We have budgeted DSRIP funds for the Project Director to work full-time for 5 months during the Prep Budget Period on these tasks in collaboration with .12 FTE senior staff from each participating Aging Services Access Point (Senior Boston Health Care, Central Boston Elder Services and Ethos).

After the Prep Budget Period concludes, we will need to continuously calibrate workloads and may need to adjust our processes, protocols and staffing in real time to reflect service demands. As new partnerships develop between the LTSS CP and ACOs/MCOs, there will be a learning curve about how best to contain cost while ensuring the full spectrum of LTSS is in place for Enrollees. The BAP will thus serve as a learning collaborative to prepare for capitation of LTSS in Year 3.

Solutions. Our plan includes processes, workflows, and systems to monitor our progress toward work plan milestones and to track enrollments, referrals, and encounters with Enrollees to ensure that achieve numerical targets as required by the contract. We also have methods in place to resolve any conflicts that may arise with ACOs and MCOs, within our Governing Body, and among the key personnel serving on the BAP Management Team. Our Quality Management Committee and Management Team will work closely with ACOs and MCOs to ensure that we meet quality targets, to be reviewed monthly along with reports from EOHHS. Finally, we have devised procedures for ongoing review and response to concerns expressed by individual

Enrollees and the CAB, including a procedure in which all Enrollee complaints are reviewed by the Management Team, with a response due to the consumer within 30 days with concurrent corrections made to protocols and procedures.

Given the developmental nature of this project, which will benefit all involved parties from the consumer up to and including EOHHS, we consider ourselves to be in full partnership with the Commonwealth and our ACO/MCO partners, with whom we share strong shared incentives to identify and resolve any challenges that may arise.

2. Assigned and Engaged Enrollees

The BAP will support the required minimum of 1,000 Engaged Enrollees—equal to more than half of the estimated 1,859 eligible individuals in the Boston-Primary service area. We understand and agree that Assigned Enrollees will not be considered Engaged Enrollees until the LTSS Care Plan has been completed. To meet our target enrollment, we expect to accept 1,250 Assigned Enrollees and engage 80% of them. However, we will accept as many Assigned Enrollees as necessary to fill available slots

3. Service Area

Our proposed service area is Boston-Primary. As described in Appendix A of the RFR, this encompasses the neighborhoods of Allston, Babson Park, Boston, Brighton, Brookline, Brookline Village, Charlestown, Chestnut Hill, Dorchester, Hyde Park, Jamaica Plain, Mattapan, Readville, Roslindale, Roxbury, Waban, Waverley and West Roxbury.

4. Operationalizing the LTSS CP

Development of the BAP LTSS CP will take place during the Preparation Budget Period beginning with execution of the contract between EOHHS in December 2017 through May 31, 2018, by which time the organization will be fully operational and ready to accept Assigned Enrollees. During this period, as the official contractor, BMC will collaborate with the ASAPs in four key areas:

- *Design, development and testing of the electronic care coordination system.* BMC will work with ASAPs and selected IT vendor to program, test, and scale the electronic care coordination system, the BAP Care Planning and Management Information System (CPMIS), which will contain Enrollee Identifying Information, Contact Information for the Enrollee and Auxiliary Contacts, Assessment Results, the Enrollee Care Plan, as well as the name and contact information for the Enrollee's the PCP, Care Team Members, and ACO/MCO. The system will ideally incorporate decision support for care transitions; contain edits to identify areas of potential duplication and/or missing information; and provide fields for baseline and follow-up data on Quality of Life (our proposed measure for Quality Improvement). It will incorporate alerts to inform the Care Coordinator when action is necessary (e.g., to achieve performance standards on Qualifying Activities and execute Documented Processes for communicating with ACOs/MCOs. It will allow for multi-disciplinary and multi-agency coordination and will have the ability to generate routine reports on Assigned and Engaged Enrollees, Qualifying Activities, and referrals for LTSS and community social services. It will have the flexibility to evolve into a full-fledged care management system. Our health IT vendor will be ACT.md.
- *Staffing of the BAP LTSS CP.* BMC and the ASAPs will collaborate on efforts to recruit, select and train new project personnel, including ten Care Coordinators, one Project Manager, and a Project Director. At a minimum, training will cover best practices in Outreach, Assessment and Care Planning, , Navigation, Motivational Interviewing, Social Determinants of Health, Community-based Resources, the Community First Vision, and

Contractual Requirements.

- *Building of BAP infrastructure and systems*. Infrastructure will include, but not be limited to, the Governing Body and Quality Management Committee, and the Consumer Advisory Board. Building of this infrastructure will include membership, procedures, and guidelines. In addition, we will devise systems and standards for all LTSS Qualifying Activities—outreach, assessment, care planning, care coordination, transitions of care, health and wellness coaching, screening and referrals for social services and/or flexible services, support for care transitions, and monitoring of services utilization. Documented Services will be another "build-out" of infrastructure. As noted previously, we have budgeted needed support for the Management Team to assist with development of all infrastructure and systems during the Prep Budget Period. We have also budgeted for subject matter assistance in pediatrics (Maypole) and on the social determinants of health (Sandel).
- *Development of management processes.* Management processes, including monitoring of services utilization, handling of grievances, quality improvement plans and procedures, reporting to EOHHS, use of CAB recommendations and EOHHS reports, and relationship of the Management Team to the Governing Body will also be developed.

  Completion of these critical functions will be the responsibility of the BAP Management Team, to include the Project Director, Project Manager and representatives of each ASAP, who will meet weekly throughout the Preparation Budget Period. Consultation will be available as needed from BMC experts in IT, Integration of Services, Children with Medical Complexity, Social Determinants of Health, and other areas. The remaining 42 months of the project period will consist of full operation of the BAP, including its Governing Body, Consumer Advisory Board, and Quality Improvement Plan.

B. Supporting Populations and Community Engagement

1. Planned Collaborations and Partnerships

Planned partnerships. Boston Medical Center (BMC) has aligned itself with three affiliated partners for the purposes of forming an organization able to serve as a Long-Term Services and Supports (LTSS) Community Partner (CP) to MassHealth Accountable Care Organizations (ACOs) and Managed Care Organizations (MCOs). These are the three Aging Services Access Points (ASAPs) currently responsible for providing LTSS to residents of the city of Boston—Boston Senior Home Care (BSHC), Central Boston Elder Services (CBES) and Ethos. Together, BMC and the three ASAPs possess the breadth and depth of expertise and experience to serve the LTSS population ages 3 to 64 years.

The ASAPs are already well known to BMC's Nurse Care Managers, Social Workers, and Navigators working in inpatient, outpatient and emergency settings throughout the hospital. These BMC providers frequently work with the ASAPs during discharge planning, as well in the context of the many BMC programs designed to address the needs of complex patients and high utilizers accessing outpatient care at BMC. The BAP will take our current relationships with the ASAPs to the next level. It will build on, standardize, and expand the availability of best practices in care coordination and achieve new economies of scale. It will make it possible to export standardized best practices to LTSS Enrollees throughout Boston, regardless of where they access care or which MassHealth ACP/MCO insures them. Through the partners, the LTSS population will have access to more than 100 community-based providers already under contract with the ASAPs, as well as those identified by project staff in the course of BAP implementation.

Planned collaborations with services providers. Together, BMC and the ASAPs offer a constellation of contractual and referral relationships with providers of home health, homemaking, transportation, rehabilitation, durable medical equipment, adult day health, personal care services, private nursing, physical therapy, occupational therapy, speech, Programs of All-Inclusive Care for the Elderly (PACE), hospice and other community-based LTSS. The three ASAPS have worked to form community connections and partnerships since their inception approximately 40 years ago and now collaborate with a range of mental health providers (e.g., Boston Emergency Services Team, CityPsych Wellness, Inc.); medical and health services providers (Boston Medical Center, community health centers, Boston Public Health Commission, Barbara McInnis House); law enforcement, legal and criminal justice services (Greater Boston Elderly Legal Services, Suffolk County District Attorney); victim's services (Jane Doe, Inc.); shelters and housing stabilization services (Pine Street Inn, Rosie's Place, Hearth, Tenancy Preservation Program); and many other community resources (food banks, congregate meal sites, churches, etc.).

BMC links directly to many of the same LTSS providers primarily through its Care Management and Social Work Departments, Center for Family Navigation, and the hospital's many programs serving people with disabilities and medically complex patients. BMC also has productive and longstanding relationships with providers of housing stabilization and emergency housing services, as well as advocacy and medical-legal partnership services. Many of these relationships are summarized in BMC's searchable database of community resources needed to address the social determinants of health in the areas of income supports, housing, education and employment, legal services, and personal safety. The database contains more than 150 providers and includes contact information, and a brief description of the provider and its services.

Recently, BMC entered into a service agreement with Aunt Bertha, a national database of resources to help meet basic needs for housing, food, health care, social services, legal assistance, employment services, income supports, and other needed services. We anticipate that the BAP will have access to this database through BMC and that Aunt Bertha will provide a wealth of information for our Provider Directory.

Other collaborations. Over and above our many collaborations with direct providers of LTSS supports and social services, BMC and the ASAPs have established strong working relationships with many of the state agencies and programs providing case management to the LTSS population, including case managers and care coordinators in the 1915(C) Home- and Community-Based Services Waiver (HCBS) Program and the Home Care Program of the Executive Office of Elder Affairs. We look forward to building upon and expanding these collaborations in the course of executing the LTSS CP contract.

2. Growing Community Connections

During the fourth and fifth months of the LTSS CP Preparation Budget Period, BMC and the ASAPs will compile their individual provider databases into a single Provider Directory and conduct a thorough assessment of existing LTSS providers to identify any areas where additional community resources are needed, using Aunt Bertha as needed. In the remaining month of the Preparation Budget Period, the BAP Management Team will work with the MassHealth Office of Long-Term Services and Supports to identify possible additions to our inventory of LTSS providers. Concurrently, the Management Team will provide outreach to key providers to obtain additional information on their capacity and ability to accept new referrals. The Provider Directory will be attached to a mobile application developed by BSHC that will make it possible

for Care Coordinators to access the database on their smart phones during home visits.

We anticipate that one of the most prominent unmet needs in the LTSS population will be for affordable housing. To address this issue, BMC has received grant funding from Robert Wood Johnson Foundation and others to formulate its "Housing Prescriptions" program, designed to create a "pharmacy" of housing solutions with which we can match families. Some of the partners involved in this project are Project Hope, which provides housing stabilization case management and a problem-solving education approach; Nuestra Comunidad, a community development corporation offering benefit maximization and financial counseling; Medical-Legal Partnership | Boston, offering deep expertise in addressing health-harming legal needs; and the Boston Housing Authority. The LTSS CP may be able to leverage this program to serve the needs of the broader LTSS population. Additionally, the ASAPs have developed and implemented an enhanced case management model in Supportive Housing sites.

Some of the other unmet needs in the LTSS population are for dental care, mental health services, transportation, and communication supports [1]. Here, the lines between the responsibility of the ACO/MCO and the LTSS CP blur. However, in the spirit of true partnership with the ACOs and MCOs who contract with us, we will bend all efforts to ensuring that needed services and supports are in place to the benefit of all parties—beginning with the Enrollee.

The Management Team will keep abreast of the need to add community LTSS providers as front-line staff report any challenges they encounter in arranging for needed services. For instance, waiting times for critical services may be unacceptable or Enrollees may complain that a particular provider is not sensitive to disability issues. Findings such as these will prompt the Management Team to continuously seek out new collaborations.

3. Maintaining Up to Date Information

The Project Director will request quarterly updates from the MassHealth Office of LTSS on newly approved MassHealth LTSS providers and any that may have closed their doors, and update the database accordingly. We will also request and receive notice of any updates to BMC database of community resources maintained by the Office of the Senior Vice President of Mission, Thea James, MD, and update the Provider Directory at least once per quarter.

C. Community Partner Supports and Activities

BAP has designed the present DSRIP Participation Plan to achieve the following goals: 1) To standardize and streamline the processes of assessment, care planning and delivery of LTSS, leveraging our existing systems and working in collaboration with the ACOs and MCOs contracting with us; 2) To improve the quality of care by matching of enrollees to best evidence-based services and supports, while optimizing enrollee choice; 3) To coordinate the delivery of services for a minimum of 1,000 Boston-based LTSS CP Enrollees at full capacity; 4) To foster integration of services and supports across domains and systems of care; 6) To participate actively and meaningfully on the Enrollee's care team; 6) To strive continuously to improve the quality of CP services; and 7) To execute the LTSS CP contract in an efficient, effective manner. Below, we describe our methods to achieve these goals.

1. Outreach, Enrollment and Engagement[1]

[1]Documented processes embedded in this section are subject to approval by ACOs and MCOs contracting with the BAP.

Locating Assigned Enrollees. Working closely with the ACOs and MCOs, we will use our services to locate Assigned Enrollees, beginning with the telephone, email and other contact information for the Enrollee, and following up with ancillary contacts. If needed, visits will be made to the last known address and/or public places the Enrollee has been known to frequent. If the Assigned Enrollee speaks a language other than English or has one or more sensory disabilities, arrangements will be made to assign a Care Coordinator who speaks the language spoken at home or to request that the ACO or MCO assign an interpreter (including a deaf interpreter if needed) to work with the Care Coordinator. A minimum of three attempts will be made to contact an Assigned Enrollee, including at least one attempt to meet in person, unless the individual prefers to meet only by phone. During the initial and each subsequent encounter with the Enrollee, the Care Coordinator will obtain updated information on the best methods to contact the Enrollee. The Care Coordinator will document all attempted and completed contacts with the Assigned Enrollee in the Care Plan.

The initial encounter with the Assigned Enrollee. The BAP will afford Enrollees the *option* to receive LTSS CP supports as required by the Model Contract (Attachment A). To assist the Assigned Enrollee during the decision-making process, the Care Coordinator will furnish an informational packet describing the LTSS CP and the services and supports available. At a minimum, the informational packet will include materials describing the functions of a CP Care Coordinator and the benefits of receiving LTSS CP supports; the option for an Assigned Enrollee to choose to or choose not to receive LTSS CP supports; if the Assigned Enrollee chooses to enroll in the LTSS CP program, the ability to request a different CP Care Coordinator from the LTSS CP or choose to receive LTSS CP supports from a different LTSS CP entity; and the process for enrolling in the LTSS CP program. Over and above these contractual requirements, we will include contact information of the Care Coordinator and his or her immediate supervisor; a description of the Enrollee Complaint Process, a Participation Form, a Sample LTSS Plan; and a description of Community First Vision and our the BAP's overarching quality target—i.e., to improve the Enrollee's quality of life across domains. All materials will underscore the important role that the Enrollee plays in designing and approving the LTSS Care Plan and choosing providers.

BAP materials will be written at a fifth grade reading level and available in English, Spanish, Haitian Creole, Cape Verdean, Portuguese and Vietnamese. Some of these materials already are available from BMC and the ASAPs; others will be developed using DSRIP funds. Versions will be available in audiotape form in these languages for visually impaired and low literacy Enrollees. We will obtain EOHHS approval for all BAP materials prior to distribution.

The Care Coordinator will review the materials with the Assigned Enrollee, answer any questions, and offer more time for the Assigned Enrollee to think about the materials and review them with family members or friends, with follow-up scheduled within five business days.

Obtaining the Participation Form. Once an Assigned Enrollee agrees to participate, the Care Coordinator will explain the purpose of the Participation Form and the uses of the Protected Information (PI), which the Care Coordinate will obtain from the Enrollee and share with authorized providers to coordinate the delivery of LTSS. Either the Assigned Enrollee or an authorized representative may sign the Participation Form, which will authorize the uses and disclosures of PI.

The LTSS Participation Form will be scanned and uploaded to the Enrollee's cloud-based Case Record, and the original copy will be maintained in a locked drawer in a locked office accessible only to the Project Director.

2. LTSS Care Planning and Management

Meaningful participation of the Assigned and Engaged Enrollee. Meaningful participation of the Assigned Enrollee in the development and management of the LTSS Care Plan will be critical to ensuring that the Care Plan reflects the goals, needs, and strengths of the Enrollee, as well as any cultural considerations, and that the Enrollee is fully invested in the Plan. To facilitate meaningful participation, the Care Coordinator will review the results of the Comprehensive Assessment completed by the ACO/MCO and meet with his or her supervisor to formulate a preliminary plan and to consider what questions the Care Coordinator will need to ask of the Enrollee. The Care Coordinator will subsequently arrange to meet with the Enrollee in the Enrollee's home or neighborhood to initiate the Care Planning process.

The Care Coordinator will begin the planning process by reminding the Enrollee that the purpose of the Plan is to make it possible for the Enrollee to have the best health, quality of life and level of functionality possible, and that the Enrollee—not the Care Coordinator--is the person in charge of the Plan. The Care Coordinator will then guide the Enrollee into a conversation about his or her goals for the LTSS Care Plan. For instance, would the Enrollee like to have additional help with homemaking, laundry, transportation? Would a Personal Care Attendant improve his or her quality of life and ability to remain at home? Could a family member assist with household duties or Activities of Daily Living (ADL)? Would he or she like to stop smoking, or improve exercise habits? Would he or she like to become stronger and more able to handle activities of daily living? To reduce the number of medications s/he must depend upon? What personal strengths can he or she build upon in service to these goals?

Toward the conclusion of the session, the Care Coordinator will administer two instruments that will be useful in completing the draft Care Plan. These will include:

- *The BAP Assessment Tool.* The BAP Assessment Tool will be based on a review of the SAMS (Social Assistance Management System) Assessments now used by the ASAPs and also incorporate elements of the adapted WECARE Tool (see below) to screen for social determinants, including unmet needs in the areas of payment for medications, housing, nutrition, income, education, personal safety, legal status, and related needs. Depending on the methods selected by ACOs/MCOs to assess people in need of LTSS, it may overlap with information provided by the ACO to the CP. To prevent duplication, the Care Coordinator will check the ACO/MCO assessment against the BAP Assessment Tool, transfer any data that applies, and limit the assessment to remaining items on the BAP Tool.
- *The Quality of Life Scale (QOLS),* which measures five domains: material and physical wellbeing; relationships with other people; social, community, and civic activities; personal development and fulfillment; and recreation (see Section I.2).

The two instruments will be administered on an iPad and electronically scored. Findings will be entered into the CPMIS. Findings will be presented to the Enrollee, along with options for LTSS that might improve quality of life and social connectedness and social services that might help with concrete needs, e.g., for nutritious food, safe and stable housing and income supports. The two instruments will be readministered at least once every six months.

Within 30 days of the initial planning session, the Care Coordinator will provide a draft plan to the Enrollee, along with suggestions for specific services. The Care Coordinator will work with the Enrollee to finalize the Care Plan and to select among available options for LTSS, with the caveat that some proposed LTSS may require prior authorization from the Enrollee's health plan. Once the Enrollee has approved the Care Plan, the Care Coordinator will seek the approval

of the Primary Care Physician (PCP) or designee. This may lead to an iterative process in which the PCP and Care Coordinator have several give-and-take discussions before an agreement is reached. Meaningful participation of the Enrollee will continue throughout LTSS Plan implementation. The Enrollee will be encouraged to contact the Care Coordinator for any issues or concerns as they arise, and the Care Coordinator will follow up, minimally, every three months, at which time the Enrollee's progress will be reevaluated and the Care Plan revised as needed. As detailed below, the Care Coordinator will notify the ACO/MCO of any changes in the functional status or LTSS needs of the Enrollee. Conversely, the ACO/MCO will notify the Care Coordinator of any emergency department encounters and/or inpatient admissions, triggering the BAP's protocol for managing care transitions. *Each of these points of intervention will offer the potential for the Care Coordinator to elicit the Enrollee's thoughts and feelings about needed changes to the Care Plan.* In addition, the administration of the Quality of Life Scale (QOLS) every six months will reignite the conversation between Enrollee and Care Coordinator on the Enrollee's well-being within and across domains and possible improvements (see Section I.2). All contacts with the Enrollee and the Enrollee's health plan will be documented as specified in the RFR #17EHSLTSSCPRFR Model Contract between EOHHS and the CP (Attachment A, page 26) and Model Contract Appendix B (ACO/MCO and CP Agreement/Contract Template).

Enrollee supports. The CP Care Coordinator will ensure that the Assigned or Engaged Enrollee receives necessary assistance and accommodations to prepare for, fully participate in and, to the extent preferred, direct the care planning process and that the Assigned or Engaged Enrollee receives assistance in understanding LTSS terms and LTSS concepts, including information on: his or her functional status; how family members, social supports and other individuals of the Enrollee's choosing can be involved in care planning and services delivery; self-directed care options and assistance available to help with self-directed care; and LTSS services the Enrollee is currently receiving or authorized to receive, if applicable.

Informed choice of providers. Each of the BAP ASAPs has multiple contracts in place for the provision of various LTSS. Once the Enrollee has approved the contents of the LTSS Care Plan, the Care Coordinator will offer at least two provider options for each type of service, using the Provider Directory, and work with the enrollee to finalize provider selection. At any time, the Enrollee may contact the Care Coordinator to request a change of providers.

Contents of the LTSS Care Plan. The BAP understands and agrees that the LTSS Care Plan, at a minimum, will contain 1) the Enrollee's preferences, strengths, challenges, interests, and LTSS goals; 2) a list of LTSS, social services and Flexible Supports providers recommended by the Care Coordinator and/or desired by the Enrollee, including names and contact information; 3) Enrollee accommodation needs; 4) a back-up plan to address contingencies in Enrollee LTSS services, including: occasions when LTSS critical services or caregivers are unavailable, when back-up transportation is needed, when emergency repair is needed for durable medical equipment, and when there is a failure of other essential supports and service; 5) a description of how LTSS will be integrated and coordinated among health care providers, BH providers, LTSS providers and community/social service providers; 6) a contact list that includes phone and email of the Assigned or Engaged Enrollee's PCP, CP Care Coordinator, ACO or MCO care coordinator, if applicable, Assigned or Engaged Enrollee's caregiver, guardian (if applicable), other natural supports or caregivers and emergency contact(s), LTSS service authorizations; and 7) LTSS service authorizations from EOHHS, where applicable, and as received from EOHHS, or its designee. We will work with EOHHS and/or our ACO/MCO partners to develop an

acceptable format(s) for the Care Plans for pediatric and adult Enrollees, to be programmed into our ACT.md Care Planning and Management Information System (see below).

Other LTSS Care Plan features. Our proposed LTSS Care Plan will be cloud-based and HIPAA-compliant with the *ability to share various levels of information among authorized individuals* who need to remain abreast of the Enrollee's functional status and LTSS Care Plans and to coordinate their services. These parties include the Engaged Enrollee's Care Team, LTSS providers, case managers from other agencies, and the Enrollee's authorized representative and family members. The Participation Form signed at the time enrollment will authorize the Care Coordinator, Care Team, and other state agencies to access the Care Plan. The Enrollee may authorize other providers and family members to access the plan at the time of enrollment or any time thereafter.

Our working model for the shared Care Plan is ACT.md, used in the 4C Program, which will accommodate the results of multidisciplinary assessments and Care Plans involving multiple agencies and providers, as well as needed documentation. The secure, HIPAA-compliant ACT.md platform can readily be adapted to meet the requirements of the LTSS Care Plan as specified in the Model Contract. It will be used to generate reports on any aspect of the LTSS Care Plans and associated documentation, and will link to the MassHIway for the purposes of information-sharing with EOHHS and our ACO/MCO partners. It will be programmed to ensure that information in the Care Plans is complete; to provide reminders of upcoming deadlines (e.g., for plan completion, plan updates, and needed contacts with Enrollees); and to alert the ACOs/MCOs to plan updates and changes in the Enrollee's status.

Our LTSS Care Plans will be prepared in the primary language of the Assigned or Engaged Enrollee and explained in this language with the assistance of an interpreter as needed. As noted, we will work with our ACO/MCO partners to ensure that alternative methods or formats (e.g., audio taping) to ensure that the Assigned or Engaged Enrollee understands the plan.

LTSS Care Plan documentation. The BAP understands that LTSS Care Plans must include documentation that the plan was provided to, agreed to, and signed by the Enrollee or authorized representative; that the Enrollee was informed that recommended LTSS are subject to MassHealth medical necessity criteria and utilization management requirements including prior authorization; that the Enrollee has been provided choice in LTSS services, programs and providers during the care planning process; and that the Enrollee has been notified of his or her rights, including the right to approve the LTSS Care Plan; the right to appeal any denial, termination, suspension, or reduction in services through MassHealth; the right to request a different CP Care Coordinator from the BAP; the right to request a different LTSS CP; and the right to submit an internal grievance to the BAP and the BAP's internal grievances procedure. Fields for this documentation will be built into our Care Planning and Coordination IT System.

Fields will also be built into the Care Plan to include the demographic information on the Enrollee and a record of communications with the Enrollee. Each communication entry will include date of contact, mode of communications, person contacted, results of the contact, planned follow-up and the electronic signature of the Care Coordinator. The results of the Comprehensive Assessment will be attached to the Care Plan, as well as the results of the WECARE Tool and the QOLS.

Finally, the ACT.md record will capture Qualifying Activities, including outreach, care planning, care coordination, care plan completion, care transitions, health and wellness coaching, and connections to community, as well as communications between the Enrollee's ACO/MCO. The record will specify the date of the activity, the mode of contact, with whom contact was

made, a brief description of what took place, and the electronic signature of the staff person conducing the activity. We will update and maintain the Care Plans and case records in accordance with all EOHHS requirements and provide a copy of the case record to EOHHS within thirty of any request.

LTSS Care Plan development and submission. The BAP further understands and agrees that the initial LTSS Care Plan must be developed, approved and signed by the Enrollee and his or her PCP or designee within 90 days of the initial assignment and, further, that the plan must be reviewed at the request of the Enrollee; and reviewed, revised and approved by the Enrollee and the Enrollee's PCP every 12 months, as well as following any major change in the Enrollee's status due to functional limitations that is not temporary or episodic. These changes may be in the Enrollee's Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), natural supports and caregivers, and/or living situation.

Completed Care Plans will be submitted to the ACO or MCO for approval by the PCP or designee and provided to the Enrollee in an appropriate and accessible format once approved.

3. Care Team Participation[2]

Integration and Communications. The Care Coordinator's participation on the ACO/MCO Care Team is an especially exciting innovation in the LTSS CP Program, and one that BMC feels especially well-qualified to design and develop. BMC's primary care practices in General Internal Medicine, Pediatrics, and Family Medicine have been certified by the National Commission on Quality Assurance (NCQA) as Level 3 Patient-Centered Medical Homes (PCMHs). These practices serve many chronically ill patients and people with disabilities. They offer integrated behavioral health services, including screening and brief cognitive-behavioral treatment for mental health and substance use disorders by a Licensed Independent Clinical Social Worker, as well as nurse care management and patient navigation services. High risk patients also are screened for social determinants and referred to community resources. The system-wide BMC electronic health record, Epic, facilitates care coordination across services and levels of care. Thus, our Care Teams are mature and high-functioning and, as such, offer a prototypical framework into which the LTSS Care Coordinator can be integrated.

In the Preparation Budget Period, the BAP Management Team will work with physician leaders in BMC's pediatric and adult practices to define the functions of the LTSS Care Coordinator on the primary care team and to workflows for the 11 Documented Processes delineated by EOHHS in Appendix B to the Model Contract between EOHHS and CPs. At a minimum, the Care Coordinator will be required to attend any special case conferences on the Enrollee's status and to follow up with the Care Team whenever the Enrollee's functional status and/or LTSS needs change, as well as within three business days of any transitions in care. The minimum standard for the Care Coordinators will be to coordinate at least once annually with the Enrollee's primary care team.

Specific duties of the Care Coordinator on the Care Team, as outlined in the Model Contract between EOHHS and the LTSS CP, include: providing information and subject matter expertise to the care team about LTSS, the Enrollee's LTSS needs and preferences, service options, provider options, accessibility requirements, and barriers to care; advocating for appropriate care; facilitating communication with other coordinators at state agencies and LTSS providers;

[2] Documented processes embedded in this section are subject to approval by ACOs and MCOs contracting with the BAP.

and promoting and facilitating the integration of LTSS across physical, behavioral and social domains.

The exchange of essential documentation will be through our dedicated ACT.md Care Planning and Coordination IT System, which will be accessible to the Care Team. Ideally, in the future, we will be able to integrate the ACT.md system into the electronic health records of our ACO/MCO partners, transmitting information across the MassHIway. We know from our experience to date with ACT.md—currently used in two BMC programs—that integration of its care management systems into electronic health records is both feasible and affordable.

The LTSS Care Coordinators also will coordinate the delivery of LTSS in the community, particularly among state agencies providing case management services. To this end, the Care Coordinator may arrange for meetings among LTSS and social services providers to discuss especially challenging cases.

LTSS Advocacy and Expertise. As described in Sections 7.2 and 7.3, the BMC and the ASAPs have substantial experience and expertise in LTSS for pediatric and adult populations ages 3 through 64 years. Given our dedication to vulnerable populations, we are also accustomed to serving as advocates. As the state transitions to full capitation of LTSS, advocacy with our ACO/MCO partners will become increasingly important.

Our philosophy in this connection is that education and advocacy are opposite sides of the same coin, and that our ACO/MCO partners, as well as Enrollees, share a common goal—i.e., maintaining the best possible health status and functionality, so that the Enrollee can achieve optimum health and functionality. We are hopeful that ongoing efforts to educate primary care teams as to the effectiveness of various LTSS and Flexible Supports, drawing on the research literature whenever possible, will minimize unfair denials, terminations, suspensions and/or reductions of services. In cases in which there is disagreement on the need for or level of LTSS, the Care Coordinator will advocate for needed services and supports in his or her interactions with the ACO/MCO Care Team. If the Team denies services the Care Coordinator deems necessary, the Enrollee will be able to appeal the ACO/MCO decision. The Care Coordinator will empower, assist and support the Enrollee in the appeals process.

Teaching our Care Coordinators to play the part of advocate will be an important part of their education and training in the Preparation Budget Period, when we will employ liberal use of role plays and guided group discussions to impart needed skills. In addition, as described below, we will provide skill training in Motivational Interviewing and Problem-Solving Education, preparing the Care Coordinators to help empower the Enrollee when an appeal is needed. Care Coordinators will be required to discuss any planned appeals with their immediate supervisors. The supervisor may choose to negotiate further with the Care Team prior to the appeal.

4. LTSS Care Coordination

LTSS care coordination activities are foundational to the work of the BAP and will take place at several levels—i.e., with the Enrollee, with the ACO/MCO, and with providers of LTSS, social services, and Flexible Supports. Initial care coordination with the Enrollee will take place during the Care Planning process, when the Care Coordinator will provide information about various options for LTSS services and programs and LTSS providers that could meet the Engaged Enrollee's LTSS needs. Once the Enrollee begins to access carehe or she will follow up with providers periodically to monitor adherence, and also invite providers to report non-adherence, which will trigger needed follow-up with the patient.

Once the Care Plan is in motion, the Care Coordinator will facilitate needed communications

among the Enrollee, the ACO/MCO, and LTSS and LTSS-related providers (see Model Contract Appendix B). During the quarterly face-to-face meeting with the Enrollee, the Care Coordinator will work with the Enrollee to assess the relevance, appropriateness, comprehensiveness, and effectiveness of the Care Plan, make needed adjustments, and obtain the necessary approvals.

Changes in status and life cycle events. Changes in the Enrollee's functional status and life cycle events may come to the attention of the Care Coordinator from any number of sources—an LTSS or social services provider, members of the ACO/MCO Care Team, a family member, an authorized representative, and/or the Enrollee him- or herself. These changes may involve deterioration of the patient's medical condition, the loss of family supports, accidental injury, cardiovascular events, changes in housing status, and any of a number of other adverse events. Any of these changes will trigger immediate notification of the ACO/MCO, which may then determine that a new Comprehensive Assessment is required. The Care Coordinator will review the LTSS Care Plan with the Enrollee within five business days and submit it to the ACO/MCO Care Team within ten working days. If the Care team subsequently revises Comprehensive Assessment, the Care Coordinator will adjust the plan as needed. (See Model Contract Appendix B.)

Strategies for engaging and empowering BAP Enrollees. BAP Care Coordinators will strive continuously to engage, motivate and empower BAP Enrollees to direct and participate in their own care. In our experience, the LTSS populations who are the focus of the LTSS CP, particularly those who experience depression and other co-occurring behavioral health problems, are more accustomed to being acted upon than to acting in their own best interests. After years of treatment by paternalistic (if well-meaning) providers, many have succumbed to a state of passivity, or learned helplessness [2]. The antidote to this condition is self-efficacy, or belief that one has some degree of control over his or her well-being and ability to effect positive changes [3-4].

Our philosophy, and that underlying the LTSS CP RFR, is that even the most compromised Enrollees can actively participate in care planning and services delivery. For this to take place, Care Coordinators must be skilled in communication methods that eliminate the traditional power differential between patient and provider and that solicit, acknowledge and value the thoughts and feelings of the Enrollee. To facilitate these communications, we propose to train our Care Coordinators to use motivational interviewing (MI) and Problem-Solving Education (PSE) as they apply to communications with diverse populations of children, adolescents and adults with LTSS needs and their parents, guardians, authorized representatives and/or family members. MI will be used to help motivate Enrollees to play an active role in their care, while PSE will be used to help foster self-advocacy.

MI employs a client-centered, non-judgmental, empathic manner, acknowledging the client's position and exploring his/her opposition or ambivalence about behavioral change [5-6]. The five main techniques used in MI are 1) expressing empathy through reflective listening, 2) developing discrepancy between client's goals or values and his or her current behavior; 3) avoiding argument and direct confrontation; 4) adjusting to client resistance rather than opposing it directly; and supporting self-efficacy and optimism. More than a set of techniques, MI has been described by its developers as "a way of being with a client [7]." An evidence-based practice, it is widely used in health care settings [8]. BAP Care Coordinators will utilize MI to explore and address ambivalence about adhering to LTSS Care Plans and other life challenges.

PSE is designed to build self-efficacy by teaching clients a simple method of problem-solving. PSE is a manualized cognitive behavioral prevention intervention adapted from Problem

Solving Treatment, an evidence-based depression treatment [9]. In a PSE session, the educator guides the subject in selecting a measurable problem, then proceeds through a series of steps including goal-setting, brainstorming, evaluating solutions, choosing a solution and implementing an action plan. Subsequent sessions review the client's progress in resolving the problem and address any barriers. PSE has been shown to reduce symptoms of depression in postpartum women and other populations [10].

MI and PSE are expected to work together, motivating Enrollees to actively engage in pursuing their LTSS goals and imparting the skills they need to resolve any challenges that may arise. The use of these methods will be regularly reviewed in individual and group supervision of the Care Coordinators.

Regular contact with the Engaged Enrollee. The BAP Care Coordinator will maintain regular contact with the Enrollee to monitor and coordinate the Enrollee's LTSS Care Plan. At a minimum, the Care Coordinator will conduct a face-to-face visit at home or in a location agreed upon by the Enrollee on a quarterly basis; make regular telephone contact with the Engaged Enrollee between face-to-face visits; provide advice and assistance in support of the Enrollee's goals and objectives; and document all visits and contacts in the Enrollee's case record.

5. Support for Transitions of Care

Plan for providing informed choices for transitions. The participation of the Care Coordinator on the ACO/MCO Care Team will be especially critical during transitions in care. Transitions from acute care to the community in particular can be fraught with potential misunderstandings and miscommunications. Patients and their caregivers and family members may be too overwhelmed at the point of discharge to understand and remember the many instructions given to them for medications, follow-up care, and potential complications. Pain after surgery may undermine their motivation to adhere to recommendations for preventing post-operative pulmonary complications and surgical site infections. The patient's functionality may have declined as result of illness or injury, and the caregivers/family may not fully understand the need for new post-discharge instructions and supports.

b.Steps to ensure stability and satisfaction. The Care Coordinator can play a vitally important role during discharge planning in arranging needed services and supports and making sure that personal care attendants and family members understand discharge instructions. After discharge, the Care Coordinator can provide continuity of care, following up with the Enrollee to see if they have encountered problems after any change of setting and notifying the ACO/MCO of any challenges encountered. In our research at BMC on Project RED (ReEngineered Discharge), we have found many barriers to adherence to discharge plans, such as a lack of understanding of the importance of certain recommendations, a lack of transportation, and a lack of co-payments for medications, to name a few [11-12].

Although the responsibility for preventing readmissions rests with the ACO/MCO, the Care Coordinator can serve as a key adviser in the development of the discharge plan and will therefore be present at discharge planning meetings, as well as other meetings to discuss changes in the Enrollee's setting. Further, the Care Coordinator will follow-up with the Enrollee within three business days of discharge to reassess the Enrollee's needs for LTSS and social services, including Flexible Services. As is the case with all revisions to the LTSS Care Plan, needed approvals will be obtained and needed enabling services arranged to facilitate access.

6. Health and Wellness Coaching

Health and wellness. As described in the preceding narrative, our Care Coordinators will receive intensive training and ongoing supervision on the use of MI and PSE—methods to motivate and empower Enrollees to remain active and engaged in achieving LTSS goals. Health and wellness coaching will employ these two methods liberally, and will be conducted at each face-to-face visit with the Enrollee. The content of health and wellness coaching will be driven by the recommendations of the ACO/MCO, and may include symptom management; prevention and management of chronic conditions; health risks such as smoking, overweight/obesity, and infrequent exercise; and adequate nutrition. Generally speaking, MI will be utilized to move Enrollees forward on the Stages of Change continuum (Precontemplation, Contemplation, Preparation, Action, Maintenance) [13-14] with respect to committing to make positive changes in their habits and behaviors. PSE will be used to help overcome perceived barriers to action and maintenance.

Importantly, the three ASAPS already offer a number of evidence-based programs and workshops to promote health, prevent disease and support the ability to live independently in the community, independently and/or in collaboration with other organizations, including Boston Public Health Commission and local community health centers. Among the topics covered are falls prevention (A Matter of Balance; Tai Chi for Healthy Aging), chronic disease self-management (My Life, My Health, Diabetes Self-Management), family caregiving (Powerful Tools for Caregivers), depression management (Healthy Ideas), brain health (Stay Sharp) and nutrition (Healthy Eating for Success). These programs have proven to be of great benefit to populations served by SCO and OneCare.

The BAP will assemble a manual of best practices in improving health habits and modifying risk behaviors that will be reviewed during the training of Care Coordinators and available to them electronically as a searchable reference. We also plan to maintain a stock of patient education brochures on various wellness topics.

7. Connecting the Engaged Enrollee to Social Services and Community Resources

Evaluating social services needs. To evaluate and connect Enrollees to social services and community resources, we plan to adapt the Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WECARE) clinic-based screening and referral system to this target populations. Pioneered by the BMC Pediatrics Department, the WECARE tool is used to screen for social determinants and address the basic needs of low-income families [15-16]. Because for many low-income families the only point of access to services of any kind is the child's medical home, the WECARE tool has proven useful in reaching families with unmet needs for fuel assistance, utilities assistance, healthy foods, and safe and stable housing. Studies have shown that parents and families feel comfortable asking for and receiving assistance from their child's healthcare provider.

WECARE is a seven-question screening tool administered at the time of a well-child visit. The survey asks the respondent to circle "Yes" or "No" next to any unmet basic needs (paying for medications, housing, transportation, food, utility bills, employment, and education). It was adapted from a larger family psychosocial screening that has a test-retest reliability of .92.

The BAP will expand the number of questions on WECARE to include issues of community and family violence, immigration status, and (other) legal problems. The Care Coordinator will administer the tool during the initial encounter and biannually thereafter for as long as the client receives LTSS. Survey results will be used to ensure that enrollees are connecting to the appropriate social services and community resources. The results of the surveys, along with

referrals to community resources, will be recorded in the patient's LTSS Care Plan.

Ensuring ongoing connections and monitoring utilization. The Enrollee's utilization of social services and community resources will be monitored by the Care Coordinator during quarterly face-to-face meetings. In addition to asking Enrollees if they have connected with the social services and community resources, the Care Coordinator may follow up directly with key social services providers or ask providers to report non-adherence.

D. Innovative Technologies

Although we have not made our final vendor selection, at the time of this writing we anticipate using ACT.md to program and maintain our cloud-based LTSS Care Coordination IT System. ACT.md is built to support complex team interactions and workflows that involve patients, families, and a broad array of care providers, each contributing aspects of a complex care plan. Care plans are accessible to all involved across care and community settings–24 hours a day, 7 days a week–supporting care transitions across the care continuum and fostering integration and collaboration across various service delivery systems, programs, providers and levels of care.

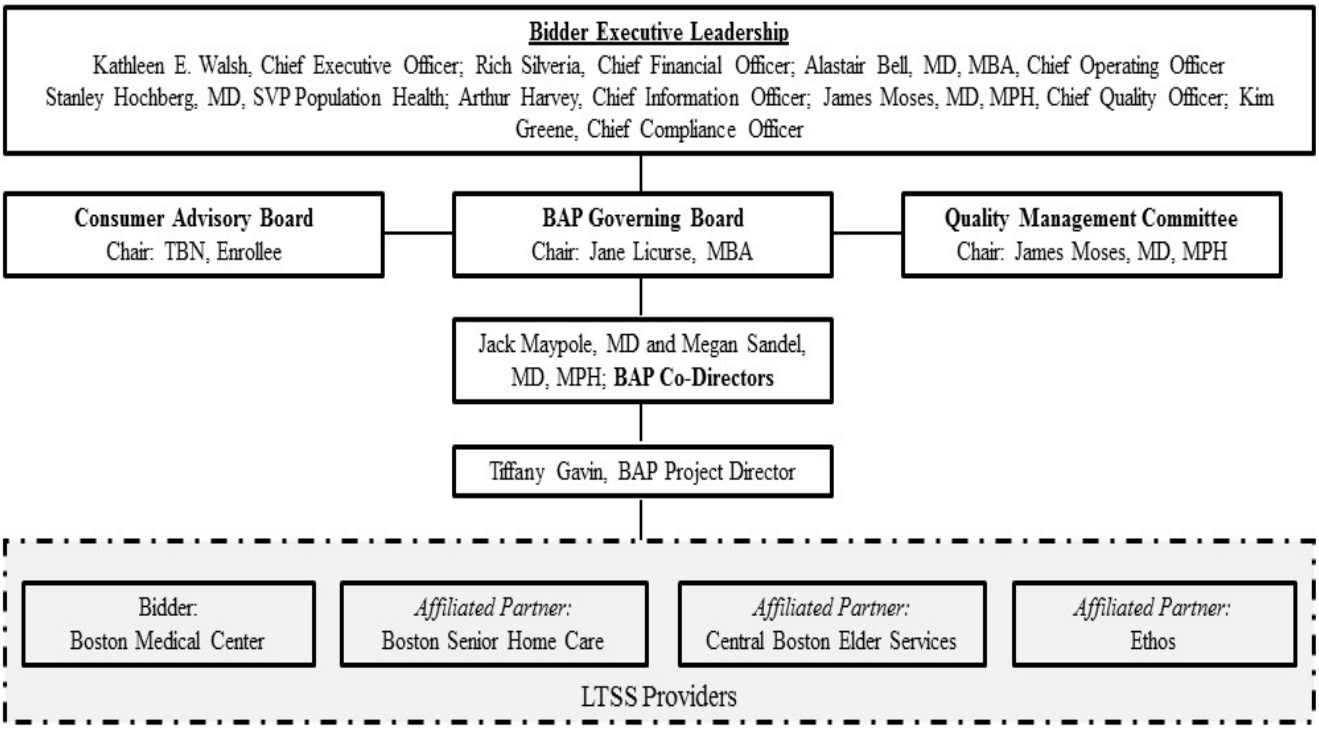
A mobile health application, ACT.md is HIPAA-compliant and allows for sharing of encrypted information by users authorized to access or edit the content of the Cares Plans and associated documentation. It offers the ability to assign and track care plan action items, as well as send reminders to patients and providers via text message. ACT.md also possesses the ability to track and report aggregated data useful in program management, including the numbers of Assigned and Engaged Enrollees, Qualifying Events, the average time to completion of the Care Plans, and adherence to other timelines and standards in the Model Contract. Data files from ACT.md can be exported and imported in real time using the MassHIway as required.

As noted, ACT.md is now in use in two BMC programs. The first, as mentioned is the 4C Program, in which ACT.md has been used to support consultative, collaborative care coordination for children with medical complexity. In this application, specialty medical and behavioral health care provided at BMC is documented and coordinated with care in the community, as well as with services provided under the Individuals with Disabilities Education Act, by the Department of Child and Family Services, and by various community-based social services providers. The other application is a HRSA-funded telemedicine initiative titled, "Delivering High Quality Care to Children and Youth with Epilepsy in Urban and Rural Settings," in which BMC pediatric neurologists consult with local pediatricians to screen, diagnosis and care for children and youth with epilepsy.

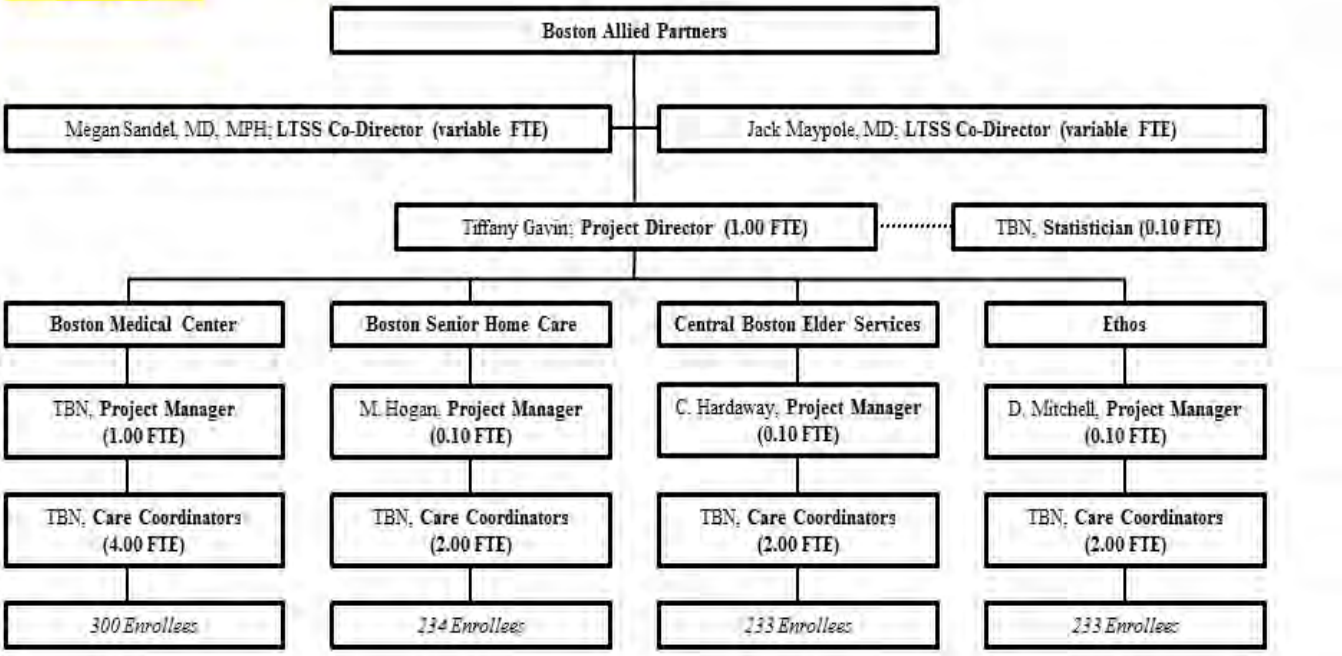
Our experience with ACT.md has demonstrated the utility and effectiveness of the ACT.md software in complex care management. It has also demonstrated that the company is customer-oriented, flexible, and affordable. We are confident that, with ACT.md as its IT vendor, the BAP will be able to "hit the ground running."

E. Personnel and Staffing

1. Organization Chart



2. Staffing Model



3. Staff Recruitment and Training

A description of the Bidder's recruitment plans, including timelines to recruit staff for any personnel positions not currently filled, and job descriptions and qualifications for each personnel position have been submitted as attachments. The job descriptions contain information regarding education, background, qualifications, credentials, and relevant recent work experience.

We plan to have several new positions filled by Month 4 of the Budget Preparation Period to ensure proper training and onboarding, including the Project Manager and four Care Coordinators. All open positions will be advertised on the organizations' Careers website as well as the popular staffing sites Indeed, LinkedIn, and Monster. Each organization will also open these positions to internal competition and all qualified staff will be considered. As a hospital and community organizations, it is important to the BAP that staff are mission driven and come from or have experience with diverse cultural and linguistic backgrounds. All staff will be subject to a Criminal Offender Records Information (CORI) check and monthly United States Office of the Inspector General's List of Excluded Individuals and Entities (LEIE) screen.

For Job Descriptions, see Attachment 7.5.E.1.

4. Recruiting Culturally and Linguistically Competent Staff

At BMC, we serve a predominantly minority patient population that is 48% black, 44% white, 6% Asian, 2% other races, and 23% Hispanic/Latino, regardless of race. As such, we hope to hire bilingual staff for this project. Because so many BMC patients are racial, ethnic and cultural minorities, our staff is highly sensitized to issues of culture, language, and gender.

All staff will be trained in the cultural competency model developed by the Diversity Curriculum Task Force of the Section of General Internal Medicine at BMC. The model is based on findings that successful cross-racial, cross-cultural care includes attention to the power differential between providers and patients, proactive demonstration of respect to redress the power differential and the clear communication of empathy. This model's value has been recognized in the American College of Physicians textbook, *Cross-cultural Medicine* [17]. Lessons are reinforced in clinic settings where cultural concerns often compete with medical problems for attention.

BSHC serves over 8,000 ethnically and racially diverse clients residing in the neighborhoods of East Boston, Charlestown, the North End, Chinatown, Beacon Hill, the West End, South Boston, Dorchester and Mattapan. BSHC believes that the diversity of its employees should mirror the diversity of the clients we serve. In our last audit, we reflected 58% diversity within our workforce. BSHC staff speaks 22 different languages including: Cantonese, Mandarin, Italian, Spanish, Portuguese, French, Haitian Creole, Vietnamese, Greek, Hebrew, Toisanese and Cape Verdean Creole. When BSHC has need to communicate in a particular language, it actively recruits staff who speak the language.

CBES serves more than 8,000 residents across the entire city of Boston. The EOEA-funded Home Care programs center on the neighborhoods of Roxbury, South End, Mission Hill, North Dorchester, North Jamaica Plain, Allston, Brighton, Back Bay, and the Fenway. Given the diversity throughout the city and its commitment to respect the cultural preferences and linguistic profiles of the populations it serves, CBES strives to employ a multicultural workforce that reflects the community and ideally is a member of it. In 2016, 14% of the workforce identified as Hispanic, 45% as African American, 27% as Caucasian and 9% as Asian. CBES staff speaks at least 15 different foreign languages including Russian, Spanish, Haitian Creole, Cape Verdean

Creole, Portuguese, Somali, and various Chinese dialects.

Ethos serves approximately 7,900 residents in the neighborhoods of Mattapan, Jamaica Plain, Roslindale, West Roxbury and Hyde Park. The major languages and cultures in the Ethos service area are English, Spanish and Haitian Creole. Ethos currently employs 28 individuals who speak these major languages. In addition, staff includes individuals who speak Cape Verdean Creole, Russian, Korean, French, Mandarin and German.

Ethos hires culturally competent individuals. Staff have access to a variety of online trainings including accessibility and accommodations, and independent living philosophy. Motivational interviewing is a cornerstone of the Healthy Ideas evidence-based program, and health and wellness principles are a cornerstone of My Life, My Health and Ethos has significant experience in training to these models. Ethos trains all employees in fraud, waste and abuse as well as conflict of interest. Ethos staff have experience with person-centered planning and with MassHealth state plan LTSS and eligibility. All new employees are trained and retrained as programs change.

5. Staff Competency and Training Requirements

In order to meet the competency and training requirements in Section 2.4B of Attachment A, all staff will be required to attend trainings on the processes, protocols, and contractual requirements for all aspects of the LTSS Care Plan, including the Comprehensive Assessment, planning process, informed choice, contents of the Care Plan, social services and flexible services assessment, documentation, development timeframes, and Care Plan submission. Staff will be required to attend these trainings upon hire and monthly beginning Budget Year 1.

6. Staff Retention Strategy

BMC. BMC's staff retention strategy is driven by our understanding that retention is an outcome of our employees' engagement with our patients and our mission, and confidence that employment at BMC will enable them to achieve their career and life goals. Our retention strategy starts with a hiring process which prioritizes offering career advancement opportunities to existing employees, and finding new hires who will thrive in our environment and culture; providing employees with information about BMC's strategies and performance, and the healthcare world, thru regular communications, Town Hall meetings, and workplace Huddles; regular goal setting and performance review discussions to enable employees to input their ideas for improvement; training in essential career and job skills enable our employees to be successful in their jobs; recognition programs which acknowledge and reward effective performance; and community engagement opportunities which enable employees to give back to their colleagues, our patients, and their communities.

Every year BMC surveys our entire staff population, to assess their level of engagement, and understand and respond to issues of concern. BMC equips Managers with tools and skills to address the immediate concerns of their employees, and remove barriers to their individual and collective success. At an enterprise level we implement initiatives which address common concerns.

Our 2016 Employee Survey showed that our staff understand and appreciate our policy of paying salaries which are competitive to the market, and we ensure that all full time and part time entry level employees make a living wage of at least $15 per hour. As well as BMC Select (the free medical plan for employees and their families), a very generous Earned Time program, and employer contribution towards our employees' retirement plans, BMC offers an employee

benefit and wellbeing program that focuses on the unique needs of our diverse employee population, with the goal of reducing daily stressors in our employees' lives; addressing issues such as affordable housing and medical care, access to healthy food, emotional resiliency programs, and free financial literacy, planning, and investment advice services.

ASAPs. The three ASAP share similar recruitment and retention strategies that include the following:

- Implementation of Stay Interviews as a proactive approach to identify staff job satisfaction and areas in which they are looking to grow professionally.
- Implement new mentoring Program to support new staff
- Implement enhanced Buddy Program to support new staff
- External training opportunities in areas of interest and need
- Expanded Social Media to attract those who look for jobs outside of traditional print
- Facebook, Twitter and upgraded LinkedIn employment postings
- New local Newspaper Placement
- Targeted Postcard mailings
- Expanded College Relations to introduce home care to those graduating

Staff retention is a major challenge to all organizations. Each organization provides a collegial environment and empowers employees to manage their workload and supports personal growth through educational opportunities including internal trainings and external conferences.

F. Implementation Plan and Timeline

F. Implementation Plan and Timeline								
Activities	**Responsible Party**	**Budget Preparation Period**						
		Q1			**Q2**			
		1	**2**	**3**	**4**	**5**	**6**
Execute BAP Memorandum of Agreement	Management Team						
Hire and train Project Manager	Management Team						
Contract with ACOs and MCOs	Management Team						
Hire and train 4 Care Coordinators	Management Team						
Design protocols for all LTSS services and management processes	Management Team						
Design/test IT system	Project Director						
Provide EOHHS with written Grievance policies and procedures for Assigned and Engaged Enrollees	Management Team						

Subscribe and connect to statewide Event Notification System (ENS)	Project Director						
Governing Body kick-off meeting	Management Team						
Consumer Advisory Board kick-off meeting	Management Team						
Quality Management Committee kick-off meeting	Management Team						
Submit Quality Improvement Plan to EOHHS	Management Team						

Activities	**Responsible Party**	**Budget Period 1**					
		Q3			**Q4**		
		7	**8**	**9**	**10**	**11**	**12**
Outreach to 200-210 Assigned Enrollees per month	Care Coordinators						
Consent and enroll 167 Assigned Enrollees per month	Care Coordinators						
Create LTSS Care Plans for Enrollees	Care Coordinators						
Administer WECARE screening tool	Care Coordinators						
Monitor Care Plans for Enrollees	Care Coordinators						
Governing Body meeting	Project Director, Governing Body, Quality Management Committee						
Quality Management Committee meeting	Project Director, Quality Management Committee						
Consumer Advisory Board meeting	Project Director						
Notify EOHHS and contracted ACOs/MCOs of ability to accept Assigned Enrollees based on capacity	Project Director						
Submit Qualifying Activities to EOHHS on a monthly basis	Project Managers						
Meet with EOHHS to discuss performance and provide written report	Management Team						

Submit monthly Member Status reports to EOHHS	Project Managers						
Submit annual Quality Improvement plan	Management Team						
Meet with EOHHS to discuss progress on meeting quality assurance measures and performance standards	Management Team						
Submit Budget Report and Budget Narrative to EOHHS for upcoming Budget Period	Project Director						
Submit Semiannual Report to EOHHS	Project Director						

Activities	Responsible Party	Budget Periods 2-5			
		Q1	Q2	Q3	Q4
Monitor Care Plans for Enrollees	Care Coordinators				
Review, revise, and approve all Care Plans every 12 months	Care Coordinators				
Administer WECARE screening tool	Care Coordinators				
Governing Body meeting	Project Director, Governing Body, Quality Management Committee				
Quality Management Committee meeting	Project Director, Quality Management Committee				
Consumer Advisory Board meeting	Project Director				
Notify EOHHS and contracted ACOs/MCOs monthly of ability to accept Assigned Enrollees based on capacity	Project Director				
Submit Qualifying Activities to EOHHS on a monthly basis	Project Managers				
Meet with EOHHS to discuss performance and provide written report	Management Team				
Submit monthly Member Status reports to EOHHS	Project Managers				
Submit Annual Report to EOHHS	Project Director				
Submit Semiannual Report to EOHHS	Project Director				

Submit annual Quality Improvement plan	Management Team					
Meet with EOHHS to discuss progress on meeting quality assurance measures and performance standards	Management Team					
Submit Budget Report and Budget Narrative to EOHHS for upcoming Budget Period	Project Director					

G. Budget Report and Budget Narrative

See Attachment A.

H. Effectiveness and Sustainability

BMC will work with EOHHS and its ACO/MCO partners to determine the return on investment of the BAP, which holds the key to its sustainability. This will be an iterative process in which the impact of the BAP on utilization and the cost of care is routinely reviewed by the BAP Management Team. To this end, we have budgeted for the use of DSRIP funds in support of a statistician from the Boston University School of Public Health who will examine utilization and cost) overall and by age, gender, LTSS population type, services utilization, and other variables of interest. We anticipate that the minimum 1,000 Enrollees served by the BAP will adequately power analyses to determine if significant effects are found for most, if not all of these variables

A number of research questions will be examined. Overall, do LTSS, social services, and/or Flexible Services bring down the total cost of care, and does this amount cover the $80 PMPM payment used to cover LTSS CP costs? Which services are most effective in containing the cost of care, for which Enrollees, and where are the greatest savings evident? How long does it take for LTSS to achieve their greatest impact? What is the optimum frequency and intensity of Care Coordinator services?

An annual formative evaluation, to be reviewed by the BAP Management Team and Quality Committee in collaboration with ACO/MCOs and EOHHS, will guide efforts to improve the overall quality of the program by strengthening the use of the most effective LTSS services and supports and focusing the time and attention of the Care Coordinators on Enrollees at highest risk. Summative evaluation will assess the overall effectiveness of the program for various populations, as well as its return on investment.

ANOVA, multiple regressions and time-series analysis will be used in the analyses.

I. Quality Management and Performance Monitoring

1. Proposed Quality Improvement Program

BMC uses the Plan-Do-Study-Act (PDSA) cycle for quality improvement. Based on the Model for Improvement [18-19] and endorsed by the Institute for Healthcare Improvement, the PDSA cycle is widely used in health care to test quality improvements in real-world settings prior to implementation. It consists of a series of systematic steps in which the team (in this instance, the Project Management Team) selects an area for improvement, gathers baseline information on performance and sets a measureable target for improvement (Plan), implements a method to

achieve the target (Do), observes the results and assesses the impact of the method on the measurable target (Study); and adopts and/or disseminates the improvement (Act). Multiple cycles allow for the cycle to start small and the team to make ongoing adaptations prior to broader implementation. Essentially, then, the PDSA is an application of the scientific method adapted for rapid learning and action in the healthcare setting.

Beginning in Year 2, the BAP Management Team will generate 1 or 2 quality improvement targets (over and above the ongoing QI initiative in Item 2 below) based on issues identified to date and review progress at least quarterly. Both process and outcome data will be used in the quality improvement program. Once satisfactory progress has been made on a particular QI target, the Team will identify another target to replace it, so that there will be one or two QI targets at any given time.

2. Proposed Quality Improvement Initiative

Our proposed QI initiative will center on improving the quality of life for BAP Enrollees. Baseline data will be recorded at the time of enrollment using Quality of Life Scale (QOLS), a 15-item instrument measuring six domains: material and physical wellbeing; relationships with other people; social, community, and civic activities; personal development and fulfillment; and recreation. The QOLS has an internal consistency of .82-.92 and a high test-retest reliability of .78-.84. Since its inception, the QOLS has been a reliable and valid instrument for measuring a patient-centered, quality of life in adults across gender, language, and cultures. (**CITATION**: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC269997/)

The QOLS will be administered to Enrollees once every six months. Chi squares and t-tests will be used to determine significance of pre/post differences overall, by age range, and by subpopulation. Analyses will be conducted every six months as well, with results communicated to EOHHS, ACOs/MCOs, the Quality Committee of the Governing Board, and the BAP staff, each of which will consider where improvements can be made in LTSS Care Planning and Management for various subpopulations to improve scores on targeted quality of life domains.

The ACT.md reporting function will be used to generate the raw data needed for the analysis, to be conducted in SPSS.

3. Composition and Reporting of QI Team

The Quality Management Committee will consist of a subset of three members of the Governing Body. Meeting quarterly, the Committee will conduct periodic audits of case records and review sentinel events, bringing these to the attention of the Governing Body, EOHHS, the Enrollee's ACO/MCO, and BMC as warranted. The Committee will review quality data furnished by the EOHHS on prevention and wellness, member care experience, avoidable utilization, integration, and engagement and work with the BAP Management Team to identify new quality targets and action plans. Members of the Committee may request special analyses from the project statistician, and also will receive and review other project-related data to assess their implications for QI.

The Quality Management Committee will provide a written report to the Governing Body on a quarterly basis, to include quarterly and cumulative findings on quality indicators and any QI trend. Members will include James Moses, BMC Chief Quality Officer; Joanne McMahan, BSHC Chief Quality and Compliance Officer; Lisa Hamilton, CBES Quality Assurance Manager; and Kathy Evans, Ethos Quality Manager.

J. Coordination with ACOs and MCOs

1. Communications with ACOs and MCOs

The BAP will communicate regularly with the ACOs and MCOs contracting for its services as required in the Model Contract, Attachment A to the RFR, and Model Contract Appendix B, which describes the required "Documented Processes" governing bilateral communications between the ACO/MCO and LTSS CP We plan to provide monthly reports to each contracting entity as follows:

- **The Member Status Report for the ACO/MCO**. For this report, we will employ the EOHHS template reporting the number of Assigned Enrollees that the BAP was NOT able to locate; the number of Assigned Enrollees as of the first of the month; the number of Assigned Enrollees declining to participate in the preceding month, and the reasons for declining; the number of Engaged Enrollees as of the first of the Month; the number of Engaged Enrollees who Disengaged in the previous month and reasons for disengagement; the number of Assigned and Engaged Enrollees with one or more Qualifying Activities completed during the month; the number of grievances made to the BAP and the resolution of the same; and the average caseload for the month.
- **The Quality Measures Report for the ACO/MCO.** The BAP will cooperate fully with EOHHS and our ACO/MCO partners to assemble the data for quarterly reports on the quality of BAP services, overall and by ACO/MCO. As described in Exhibit 2 in RFR Appendix C, the EOHHS template for the Quality Measures Report is expected to assemble data from a variety of sources—the National Commission on Quality Assurance; the Dental Quality Alliance, reviews of medical charts, the National Quality Forum, 3M, EOHHS claims, and surveys of Enrollees. Many of these measures consist of protected health information that is already tracked by ACO/MCO providers and EOHHS and will not be tracked by BAP as they would require additional follow-up beyond the capacity of our Care Coordinators (who will track referrals and follow up on reported non-adherence, but who will not have time to follow-up on every appointment), as well as duplicative data entry. Among the measures best tracked by the ACOs/MCOs and EOHHS using claims are well-child visits, adolescent well-care visits, oral evaluations/dental services, annual adult primary care visits, all-cause readmissions, and potentially preventable ED visits. Measures that will be documented in our electronic case records and reported to EOHHS include social services screenings, completion of the initial LTSS Care Plan within 90 days, and annual updates to the Plan. We will also be able to generate reports on other contractually mandated timelines, including updating of the Care Plans after care transitions and major life event/changes in status. In addition, the BAP is open to administering Enrollee surveys on service delivery; health and wellness, choice and control/consumer voice and perceived quality of care. Finally, we will report to our partnering ACOs/MCOs on the quality measures selected by the BAP Management Team for our QI Program (see Sections I.1 and I.2).

The BAP also will keep ACOs/MCOs abreast of any changes reported in the functional status or living situations of Enrollees, as well as any updates to the individual Care Plans of Enrollees.

Special meetings may be called at the discretion of the BAP or the contracting ACO/MCO to discuss aspects of the Member Status and/or Quality Measurement Reports and engage in joint problem-solving.

2. Branding and Marketing Plan

Our brand is Boston Allied Partners, and we will include our logo (to be designed) on any printed educational and/or promotional materials. Our marketing plan, quite simply, is to meet with all the EOHHS-approved ACOs and MCOs serving residents of Boston during the Preparation Budget Period, to walk through our LTSS CP Program and the Model Contract (and any subsequent versions) prepared by EOHHS, and to finalize contractual requirements. We will include at least one ASAP representative in these meetings, which will be led by Dr. Maypole and Ms. Gavin. They will provide a packet of promotional materials to our potential partners delineating our philosophy, staffing, approach to partnering with ACOs/MCOs, methods for Care Planning and Coordination, planned reports, and other relevant materials. These materials can be shared at an educational lunch-and-learn session.

BMC is a known entity to MassHealth MCOs and emerging ACOs, as are the ASAPs, and we believe that the BAP has a high level of operational readiness to implement the LTSS CP. Thus, we see little need for more extensive marketing of BAP services.

3. Collaboration Strategy

The BAP will have two levels of collaboration with our ACO/MCO partners. The first, as described in Sections C.1 and C.2, will involve front-line collaborative assessment and care planning processes, mutually agreed upon Care Plans for BAP Enrollees, and inclusion of the LTSS CP Care Coordinator on the ACO/MCO care team. The second level of collaboration will consist of routine reports (see Section J.1) ongoing communications in which the Project Director and Management Team engage with the ACOs/MCOs to resolve grievances and conflicts (see below).

4. Conflict Resolution Strategy

Many safeguards to prevent conflict are built into the Model Agreement and this DSRIP Participation Plan. Even more fundamentally, the BAP and the ACOs/MCOs share the same overarching goals to maximizing the independence, functioning, and satisfaction of Enrollees. Nevertheless disagreements may arise regarding the best methods to use to achieve these goals. Should any conflicts of this nature arise in the course of contract execution, the BAP and ACO/MCO partner will refer them to a mutually agreed upon third party with expertise in the area being disputed. Conflicts may also arise as to the interpretation of the requirements in the BAP contract with an ACO/MCO. Should this occur, the matter will be referred to EOHHS for resolution. Once an immediate resolution is achieved, the Management Team will assess if the problem was a one-time issue, a systemic problem, or an incident requiring changes in policy. A root cause analysis may be conducted as necessary.

A foremost consideration in problem solving is to ensure that the issue does not continue to arise and impact the ability of the team to provide high-quality, cost efficient coordinated services. The best practice in this regard is to maintain ongoing, regular meetings that facilitate and foster communication within the interdisciplinary team to prevent conflicts from arising.

K. Providing Culturally Competent and Informed Services and Supports

1. Cultural and Linguistic Competence

Language and communication assistance. Broadly speaking, issues of age, race, ethnicity, culture, language, sexual orientation, disability, literacy, and gender will be considered throughout the duration of the contract. All patient materials will be available in English,

Spanish, Haitian Creole, Cape Verdean and Vietnamese, as well as in audio format. Care Coordinators will be trained to ask Enrollees if they would like to have important documents read out loud to ensure all literacy issues are appropriately addressed.

BMC offers language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. The BMC Interpreter Services Department is one of the most extensive in New England. In addition to providing face-to-face interpreters on-site in 21 spoken languages, American Sign Language and Certified Deaf Interpreting, the department utilizes the latest advances in technology such as telephonic and video interpreting, providing coverage 24 hours a day, 365 days a year. We have budgeted DSRIP funds to pay for these services, in the event that our ACO/MCO partners cannot cover them.

b. Informing Enrollees of available assistance. Enrollees will be informed about available assistance at the time of enrollment and initial assessment, and at each quarterly check-in meeting with their assigned Care Coordinator. Care Coordinators will connect enrollees to health education and social support; neighborhood resources for culturally responsive social services; and supports overcome barriers to accessing services. Additionally, Care Coordinators will provide the three types of support, expressing empathy and concern; providing access to needed concrete supports; and educating them about their health, the importance of preventive and primary care, and available services and supports.

c. Responsiveness to diverse beliefs and practices. BMC embraces all forms of diversity. Our providers are passionate about the hospital's safety net mission and pleased to serve our "majority minority," low-income populations and take pride in our ability to provide culturally and linguistically appropriate care for people of all races/ethnicities and sexual orientations.

We are acutely aware of the different beliefs, behaviors, and roles surrounding issues of health and disability related to our target populations. To the extent possible, the proposed CAB will reflect the racial, ethnic, linguistic, and gender diversity of the Enrollees we will serve. In addition, the evidence-based practices to be built into our program have been (or will be) evaluated with diverse populations, consulting as needed with BMC personnel who have experience with various populations. All hospital staff participates in mandatory yearly refresher trainings on cultural sensitivity and has access to ongoing supports and resources provided by the hospital. Cases in which individual differences influence the delivery of care will be immediately brought to the attention of the Program Director for review, who will assess the issue and implement corrective action as needed or seek additional supports to corrective the issue.

2. BMC and ASAP Experience in Serving Diverse Populations

Individuals experiencing homelessness. Boston Healthcare for the Homeless is a Section 330 funded community health center affiliated with BMC through Boston Healthnet, an affiliation of BMC, Boston University School of Medicine, and 13 community health centers. BMC therefore serves as the tertiary care center for much of Boston's homeless population.

BMC also has several programs targeting homelessness prevention and care of the homeless. BMC's Elders Living At Home Program (ELAHP) has been providing intensive case management services to homeless and at risk older adults since 1986. In the last 31 years, ELAHP has served more than 4,000 individuals, and more than 80% of the time overall homelessness was ended or prevented. ELAHP's retention rate—individuals maintaining housing once they have initially transitioned or stabilized—has remained at about 95%. Over the past 31 years, ELAHP staff have developed innovative and collaborative solutions to address

elder homelessness, including the first in the state emergency housing program.

LGBTQ populations. In 2015, we opened our Transgender Clinic, a regional referral center for patients transitioning to a gender other than that on their birth certificates. In 2016 BMC was named by the Human Rights Campaign (HRC) Foundation as one of 303 facilities nationwide qualifying as a "Leader in LGBTQ Healthcare Equality." This designation was based on HRC's determination that we provide "LGBTQ patient-centered care, patient services and support, employee benefits and policies and patient and community engagement."

Criminal justice-involved individuals. In 2006 BMC founded the Violence Intervention Advocacy Program (VIAP) as a way to stem the tide of gun and knife violence in Boston's neighborhoods. Violence has long-lasting effects on the victim and his or her family and simultaneously impacts the quality of life throughout the surrounding neighborhood and larger community. As the busiest and largest Level 1 trauma center in New England, BMC treats 70% of the city's gunshot and stabbing victims, averaging 465 cases per year, with 68% of them being boys and young men of color.

When a gunshot or stabbing victim is admitted to the hospital, the victim is visited by a Violence Intervention Advocate within 48 hours to begin case management, which includes being assigned a care management team comprised of a case manager, mental health clinician and family support advocate to help them break down barriers and turn their life around. As the victim heals, the VIAP team continues the 360-degree treatment program that includes counseling, safety planning, job and educational training, mental health, and family support services.

Individuals who are blind, low vision, deaf or hard of hearing. BMC has made many accommodations for blind and low vision individuals and frequently provides care, including surgical treatment and low vision rehabilitation, to visually impaired patients in its Ophthalmology Clinic. Examples of low-tech, low-cost accommodations made for these patients include braille signage throughout the hospital, lighting adjustments, use of large print, and having staff read documents to patients. Service animals are welcome at BMC. In addition, BMC Volunteer Services assigns Patient Ambassadors to greet, welcome and accompany patients with disabilities to appointments across the campus.

Patients with hearing impairments are assigned a sign language interpreter to assist during encounters. TTY is also available on all of the phones at BMC for additional assistance.

Individuals with cognitive disabilities. Patients with cognitive and developmental challenges are frequent visitors to BMC, which has developed special programs and low literacy materials for these patients in several areas of the hospital, including Family Medicine and the Diabetes Clinic. All patient education materials and consent forms are written at the fourth grade level, and clinical staff will offer to read these materials aloud if the patient is unable to read at that level. In these cases, staff often use the "teachback" method to make sure that patients understand important points.

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Community Partner Program Budget Report

Elder Services of the Merrimack Valley, Inc.

	Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
	Estimated Enrollees- Start of Period (All Enrollees)		0	1,125	1,125	1,125	1,125	
	Estimated Enrollees - End of Period (All Enrollees)		1,125	1,125	1,125	1,125	1,125	
	Estimated Enrollees - Monthly Average		609	1,125	1,125	1,125	1,125	
	Total Estimated Program Revenue		**$ 340,800**	**$ 1,080,000**	**$ 1,080,000**	**$ 1,080,000**	**$ 1,080,000**	**$ 4,660,800**
	At- Risk Withhold Rate			0%	0%	0%	0%	
	Withhold funds			$ -	$ -	$ -	$ -	$ -
	Revenue for Operations		$ 340,800	$ 1,080,000	$ 1,080,000	$ 1,080,000	$ 1,080,000	$ 4,660,800
	Program Expenses	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
1	**Salary**	$ 104,583	$ 396,458	$ 803,400	$ 767,826	$ 790,861	$ 820,696	$ 3,683,825.82
2	**Fringe**	$ 24,577	$ 93,168	$ 188,799	$ 180,439	$ 185,852	$ 192,864	$ 865,699.07
	Total Personnel Costs	$ 129,161	$ 489,626	$ 992,199	$ 948,266	$ 976,714	$ 1,013,560	$ 4,549,525
3	**Training & Professional Development**	$ -	$ -	$ -	$ 5,100	$ 5,100	$ 5,100	$ 15,300
4	**Travel**	$ 1,000	$ 6,625	$ 12,000	$ 9,750	$ 9,750	$ 9,750	$ 48,875
5	**Equipment**	$ 3,500	$ 3,500	$ 6,000	$ 6,000	$ 6,000	$ 6,000	$ 31,000
6	**Supplies**	$ 520	$ 2,090	$ 4,080	$ 3,900	$ 3,900	$ 3,900	$ 18,390
7	**Contract Services** (consulting, professional)	$ -	$ 6,533	$ 11,200	$ -	$ -	$ -	$ 17,733
8	**Software licensing**	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	**Telecommunications**	$ 1,873	$ 8,970	$ 17,291	$ 17,028	$ 17,028	$ 17,028	$ 79,219
10	**Occupancy** (rent, utilities, maintenance)	$ 8,586	$ 30,051	$ 51,516	$ 51,516	$ 51,516	$ 51,516	$ 244,701
11	**Other**	$ -	$ 8,767	$ 15,029	$ 15,029	$ 15,029	$ 15,029	$ 68,881
	Total Direct Costs	$ 144,639	$ 556,162	$ 1,109,314	$ 1,056,589	$ 1,085,036	$ 1,121,883	$ 5,073,624
12	**Indirect Cost/Administrative Overhead** **10.0%**	**$ 14,464**	**$ 55,616**	**$ 110,931**	**$ 105,659**	**$ 108,504**	**$ 112,188**	$ 507,362
	TOTAL EXPENSES	$ 159,103	$ 611,779	$ 1,220,246	$ 1,162,247	$ 1,193,540	$ 1,234,071	$ 5,580,987
	Surplus/Shortfall	*$ (159,103)*	*$ (270,979)*	*$ (140,246)*	*$ (82,247)*	*$ (113,540)*	*$ (154,071)*	*$ (920,187)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total		
Senior Management	$ 100,000.00	0.00	0	$ -		
Program Director	$ 80,000.00	1.00	6	$ 40,000	6.00	
Managers	$ 65,000.00	1.00	7	$ 37,917	7.00	
Data Quality Manager	$ 75,000.00	0.00	7	$ 0	0.00	
Intake/Administration	$ 40,000.00	1.00	1	$ 3,333	1.00	
Navigators (POC & Field)	$ 40,000.00	7.00	1	$ 23,333	7.00	
				$ -	21.00	420.00014
				$ -		
				$ -		
Total Salary (Program Budget Line 1)		**10.00**		**$ 104,583**		

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 104,583.38	23.5%	$ 24,577
Total Fringe (Program Budget Line 2)			

Total Personnel*	**$ 104,583**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

Senior Leadership: To provide strategic and operational leadership for the program. This includes the leadership team from both NILP and ESMV. This is proposed to be funded through an "inkind" and indirect.
Program Director: The LTSS CP Program Director is responsible for working collaboratively with the Care Coordination Directors to lead and direct the Care Coordination Department including planning, program development, quality improvement efforts, staff and interdisciplinary team development, compliance issues and customer service. Also serves as key liaison to ACO leadership during startup.
Manager: Day to day supervision of the navigators. Monitor daily triage and Intake distribution. Manage caseload coverage and redistribution as needed. Other special projects related to coaching, training, quality, customer services and ACO support. During start up, works to design and test workflows and training materials.
Data Quality Manager: Develop, implement and monitor systems and processes for quality assurance to measure compliance with LTSS CP standards, consistent with the goals, vision and values of ESMV. Provide education and coaching to direct service staff relative to Quality Assurance. This position is funded by DSRIP funding during the PBP.
Intake/Administration: To provide administrative support to the Long Term Supports and Services Program and staff. Receive referrals for Assigned Enrollees, enter data into eHana Care Management platform and assign referral to Point of Care Navigator for outreach.
Navigator: To assist Assigned Enrollees to make informed choices about receiving LTSS CP Supports and promote coordination in the delivery and receipt of LTSS services to Enrollees.

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Total Training and Professional Development (Program Budget Line 3)			

Provide a description of each Training and Professional Development line item included in the table above:

There are no training and professiona development items in the prep budget period other than the NILP provided Disability Awareness Training. Training for the navigators is funded through the salary line for their first month of hire, which is included above.

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
Program Director	100	6	0.50	$ 300.00
Managers	100	7	0.50	$ 350.00
Data Quality Manager	100	7	0.50	$ 350.00
Intake/Administration				$ -
Navigators (POC & Field)				
				$ 1,000.00

Travel Expense Description	Cost
Total Mileage	$ 1,000.00
Parking and tolls	
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ 1,000.00**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

The above estimates assume that staff will travel an average of 25 miles per week. These meetings will occur between NILP and ESMV, between ESMV offices and EOHHS and between ESMV and the ACO sites. No enrollee expenses are anticpated in the Prep Budget Period.

Row 5 - Equipment

Description of Equipment	Unit Cost	#units or FTEs	Cost
Copier/Printer Monthly Lease Cost - 1 Copie	500	1	$ 3,500.00
Total Equipment (Program Budget Line 5)			**$ 3,500.00**

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

The copier/printer is for day to day office use for all LTSS CP staff. The monthly cost is estimated based on a quote from the copier vendor.. The calculation is based on a monthly cost of $500 times 7 months which is the duration of the prep budget period.

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost	
Office Supplies	$ 22.86	22.75	$ 520.00	$ 520.00

	A	B	C	D	E	F	G
163							
164							
165							
166	**Total Supplies (Program Budget Line 6)**			**$ 520.00**			

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

This is to cover general office supplies such as paper, toner, pens, folders etc.This also includes shredding. The costs are estimated at ESMV historical spending levels. The units above are calculated by FTE x the # of months.

Program Director 1 FTE for 6 Months = 6
Managers 1 FTE for 7 Months = 7
Navigators/Intake 8 FTES for 1 Month = 8
Data Quality = .5 FTE for 3.5 Months = 1.75
Total "FTES/Months" = 22.75

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			**$ -**

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

There are no contractor services anticipated during the prep budget period.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
		Total Software Licensing (Program Budget Line 8)	

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

There are no software licensing costs anticpated duringthe prep budget period. It is anticipated that we will incur costs for a one time purchase of eHana software and then for each member enrolled which will start in budget period 1. Costs related to the care management software are included in the DSRIP budget.

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Landline Phones	29.2	21.00	$ 612.59
Mobile Phones	63.0	20.00	$ 1,260.00
Total Telecommunications (Program Budget Line 9)			**$ 1,872.59**

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

The telecommunications line supports desk phone service for all staff and a mobile phone and mobile laptop for all positions except the data quality manager and the intake coordinator which are not considered "mobile" positions..

Landline Phones
Program Director for 6 months
Manager for 7 months
7 Navigators for 1 month
1 Intake Coordinator for 1 month
Total "FTES/Months" = 21

Mobile Phones
Program Director for 6 months
Manager for 7 months
7 Navigators for 1 month
Total "FTES/Months" = 20

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent	3,240	13	$ 7,020.00
Utilities			$ 621.00
Repair and Maintenance			$ 945.00
			$ -
			$ -
Total Occupancy (Program Budget Line 10)			**$ 8,586.00**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how

the costs were determined:

Merrimack Valley Community Partnership (MVCP) will rent additional space from the current ESMV landlord to accomodate the new staff. This is anticipated to begin 4/1/18. Therefore the occupancy budget reflects 2 months of costs during the prep budget period.

The above numbers have been corrected as we uncovered a formula error. The anticipated square feet is 3,240 and the price per sq foot is $13. The square foot estimate includes an allocation for common space such as conference rooms, rest rooms and lunch rooms.

Row 11 - Other

Other Direct Expense Description	Cost
Insurances	$ 300.00
Total Other Direct Costs (Program Budget Line 11)	**$ 300.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Insurance will be charged to the program when the major hiring occurs in early May. Therefore the amount assumed in the DSRIP budget is minimal. The allocation and rates are based on our current insurance.

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead	**10.00%**	**$ 14,493.91**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

The assumed indirect rate is 10% for the prep budget period. This is consistent with ESMV's rate. The rate may change in years 1 to 5 as NILP has a higher rate as their agency is smaller. The indirect allocation covers staffing for senior management , Human Resources, Core IT, Finance, Billing and Legal. It also includes costs associated with that staff such as occupancy and travel.

Community Partner Infrastructure Budget Report

Elder Services of the Merrimack Valley, Inc.

		Infrastructure Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
		PMPM Infrastructure Rate		$ 75.00	$ 49.72	$ 43.28	$ 36.40	$ 29.34	
		Engaged Enrollees		1,125	1,125	1,125	1,125	1,125	
		Estimated Infrastructure Funds		$ 590,625	$ 671,220	$ 584,280	$ 491,400	$ 396,090	**$ 2,733,615**
		At- Risk Withhold Rate			25%	44%	63%	81%	
		Withhold			$ 167,805	$ 257,083	$ 309,582	$ 320,833	**$ 1,055,303**
		TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 590,625	$ 503,415	$ 327,197	$ 181,818	$ 75,257	**$ 2,128,312**
		Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
		Technology							
1		**IT Staffing including Fringe**	$ 25,000	$ 58,333	$ -	$ -	$ -	$ -	**$ 83,333**
2		**Development Adaptation of EHR and/or Care Management System**	$ 149,000	$ 48,625	$ 40,500	$ 65,500	$ 65,500	$ 40,500	**$ 409,625**
3		**Technology for Service Delivery**	$ 25,500	$ 4,500	$ -	$ -	$ -	$ -	**$ 30,000**
4		**Other Technology Expenses**	$ 1,200	$ -	$ -	$ -	$ -	$ -	**$ 1,200**
		Total Technology	$ 200,700	$ 111,458	$ 40,500	$ 65,500	$ 65,500	$ 40,500	**$ 524,158**
		Workforce Development							
5		**Workforce Development staffing including Fringe**							**$ -**
6		**Recruitment Expenses**	$ 2,000	$ -	$ -	$ -	$ -	$ -	**$ 2,000**
7		**Training Expenses**	$ 10,000	$ -	$ 10,000	$ 10,000	$ 10,000	$ 10,000	**$ 50,000**
8		**Retention Expenses**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
		Total Workforce Development	$ 12,000	$ -	$ 10,000	$ 10,000	$ 10,000	$ 10,000	**$ 52,000**
		Business Start Up Costs							
9		**Office Equipment (PBP & BP1 only)**	$ 5,066	$ 894					**$ 5,960**
10		**Office Furniture (PBP & BP1 only)**	$ 16,014	$ 2,826					**$ 18,840**
11		**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**	$ 159,103	$ 270,979	$ 140,246	$ 82,247			**$ 652,575**
		Total Business Start Up Costs	$ 180,183	$ 274,699	$ 140,246	$ 82,247	$ -	$ -	**$ 677,375**
		Operational Infrastructure							
12		**Operation Staffing including Fringe**	$ 27,016	$ 169,298	$ 203,528	$ -	$ -	$ -	**$ 399,842**
13		**Other Operational Expenses**	$ 3,000	$ -	$ -	$ -	$ -	$ -	**$ 3,000**
		Total Operational Infrastructure	$ 30,016	$ 169,298	$ 203,528	$ -	$ -	$ -	**$ 402,842**
14		**Indirect Cost/Administrative Overhead Rate**	10.0% $ 26,380	$ 28,448	$ 25,403	$ 7,550	$ 7,550	$ 5,050	**$ 100,380**
		TOTAL INVESTMENTS	**$ 449,278**	**$ 583,903**	**$ 419,677**	**$ 165,297**	**$ 83,050**	**$ 55,550**	**$ 1,756,755**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
IT Consultant	$ 42,857.14	1	7	$ 25,000
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	1		$ 25,000
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 25,000**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

MVCP will contract with an IT Consulting firm to supplment our IT Departments to assist in the implementation of the care management software . The scope will include project management, requirements gathering, system roles, security, workflow , reporting and initial training.

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Purchase of Care Management Software	$ 149,000.00

	A	B
34		
35		
36		
37		
38		
39	**Total Development and Adaptation of EHR and Care**	
40	**Management System**	$ 149,000.00
41	**(Infrastructure Budget Line 2)**	
42		

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

MVCP is planning to work with eHana to deploy care management software. We anticipate having a signed contract by mid October. The contract is currently b eing negotiated. We have assumed staggered payments based on key deliverables and milestones. The solution offered by eHana includes:

- a comprehensive workflow solution covering all CP requirements for Assessment, Care Planning, Consents, Participation Forms, and Activity Notes, including signoff and approvals
- Analytics and benchmarking for key quality and performance indicators
- Complete MassHealth billing and eligibility for Community Partner activities
- Standards-driven interoperability with EOHHS, Accountable Care Organizations, and Electronic Health Records
- Robust security architecture to support Community Partner collaborative entities, stand-alone CPs, and affiliated partners

Row 3 - Technology for Service Delivery

	Description of Expense	Cost
60	Laptops to use Care Management Software	$ 25,500.00
61		
62		
63		
64		
65		
66	**Total Technology for Service Delivery**	$ 25,500.00

	A	B	C	D	E	F	G
67	**(Infrastructure Budget Line 3)**	$ 25,500.00					

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Each Navigator will have a laptop so that the care management software can be deployed in the field. We estimate the purchase of 17 laptops at a current price of $1,500 each.

Row 4 - Other Technology Expenses

Description of Expense	Cost
Switch Modules	$ 1,200.00
Total Other Technology Expenses (Infrastructure Budget Line 4)	

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

The budget includes $1,200 for switch modules at a cost of $600 each to accomodate the additional networking requirements of new staff.

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 6 - Recruitment Expenses

Description of Expense	Cost
Recruitment Expenses	$ 2,000.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

MVCP will spend approximately $2,000 on "Indeed" advertisements to support the hiring of all positions including the Navigators. It is anticipated that 2-3 positions will be filled with internal candidates.

Row 7 - Training Expenses

Description of Expense	Cost
Cultural Competence Training	$ 9,000.00
Other Staff Training	$ 1,000.00
Total Training Expenses (Infrastructure Budget Line 7)	**$ 10,000.00**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

The Northeast Independent Living Program, Inc. (NILP) is a consumer controlled, cross-disability Independent Living Center. NILP's Education Division, The Training and Learning Collaborative (TLC) is comprised of a qualified team of professionals who are persons with disabilities and/or have many years of training and consulting experience in the disability community. NILP designs and delivers customizes training to address the needs of healthcare providers and community organizations to better serve the needs of their members, patients, and clients resulting in improving the integrated health care delivery system to provide self determined models of care in the least restrictive environments. Core Tenets of Cultural Competence Training for LTSS CP Training include:

- Compare and Contrast the Person Centered Planning and Consumer Directed Models of Care. Why? Transfer the knowledge of IL history, values and beliefs to meet the diverse needs of ACO members living with chronic conditions.
- ADA and Cultural Competence : Beyond Compliance
Health Care Disparities – consumer stories and examples demonstrating the need for a paradigm shift in making health care access an equal benefit for all.
- Communication and Cultural Competence with diverse experiences, belief systems and cultures within the disability Community. For Example: DEAF, Recovery, Ethnicity, Gender, and the intersectionality of our community.
- LTSS CP roles and community perspectives in how to ensure the ACO enrollee's preferences, needs and self determination are met in the Integrated care planning teams.

This training will be provided to key staff throughout ESMV, the LTSS management team and navigators. It will also be offered to ACO partners and CBOs in subsequent periods.

Additional Detail Added 11/15/17

The training provided by NILP consists of 4 modules provided over a 3 day period. Each hour of training is $375. The 3 day training will cost $9K.

The cost for each full-day training session (all 4 modules) was established as $3,000.00 per full day 8 hour training session. This cost is inclusive of our training design and preparation hours. (Formula: 1 hour of preparation for each 1 hour of training or $375.00 per each one hour = $3,000.00 for a full-day training session.) The targeted audience for the training is direct and indirect staff involved in serving the LTSS Community members. Please note that TLC provides all pertinent handout materials for the participants and also **offers CEU's through the NASWs and is recognized and transferrable for Nursing CEU's.**

Lastly, it is important to note that our TLC Training Sessions are very interactive therefore we keep an absolute maximum cap of **30 students** per each training session so that the participants can best absorb the impact and positive outcomes of our TLC curriculum. The targetted audience for the initial training will be the LTSS CP staff and senior managers within ESMV. If space allows, we may invite key contacts within our ACO partners though the plan is to offer this training to our network and partners in later phases of the initiative.

Backup for NILP Disabality Cultural Competence Training Training

Hours Per Day	8
Cost Per Hour	$375.00
# of Days	3
Total	$9,000
# of People Trained	30
Cost Per Person	$300.00

In addition to the Disability Cultural Competence Training, we have set aside an additional $1,000 for other trainings that staff may need such as Performance Management and Analytics, Care Delivery Transformation, or Clinical Integration.

Row 8 - Retention Expenses

Description of Expense	Cost

	A	B	C	D	E	F	G
232							
233							
234							
235	**Total Retention Expenses**						
236	**(Infrastructure Budget Line 8)**						
237							
238	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of***						
239	***the CP's contract and how the costs were determined:***						
240							
241	*There are no retention expenses included in the prep budget period.*						
242							
243							
244							
245							
246							
247							
248							
249							
250							
251							
252							
253							
254	**Community Partner <u>Infrastructure</u> Budget Report - Business Start Up Costs - Prep Budget Period**						
255							
256	**Row 9 - Office Equipment**						
257	Description of Expense	Cost					
258	Office Equipment	$ 5,066.00					
259							
260							
261							
262							
263							

	A	B	C	D	E	F	G
264	**Total Office Equipment**	**$ 5,066.00**					
265	**(Infrastructure Budget Line 9)**						
266							
267	***Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were***						
268	***determined:***						
269							
270	*This budget line item includes the cost of a landline phone, phone system license, business cards, security badge (door key) and parking*						
271	*pass. The cost is estimated to be $298 per person which is multiplied by 17 individuals.*						
272							
273							
274							
275							
276							
277							
278							
279							
280							
281							
282							
283	**Row 10 - Office Furniture**						
284	Description of Expense	Cost					
285	Chair & Cubicles	$ 16,014.00					
286							
287							
288							
289							
290							
291	**Total Office Furniture**						
292	**(Infrastructure Budget Line 10)**						
293							
294	***Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:***						
295							
296	*This budget line item includes the cost of cubiicles and charis. The cost is estimated to be $942 per person which is multiplied by 17*						

individuals

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Data Quality Manager (.5)	$ 75,000.00	0.5	7	$ 21,875.00
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0.5		$ 21,875.00
	Fringe rate	23.5%	Total Fringe	$ 5,140.63
			Total Program Staffing including Fringe (Infrastructure Budget Line 12)	**$ 27,015.63**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the

terms of the CP's contract:

Data Quality Manager: Develop, implement and monitor systems and processes for quality assurance to measure compliance with LTSS CP standards, consistent with the goals, vision and values of ESMV. Provide education and coaching to direct service staff relative to Quality Assurance. This position is partially funded in the program budget and partially funded in the DSRIP budget.

Row 13 - Other Operational Expenses

Description of Expense	Cost
Marketing	$ 3,000.00
Total Other Operational Expenses (Infrastructure Budget Line 13)	

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

This line item funds development, print and marketing materials to share with ACOs and CBOs as well as resource materials that we will give enrollees. It also includes a small allocation to adapt our website to include the LTSS CP program.

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**10.00%**	**$ 26,379.56**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

The assumed indirect rate is 10% for the prep budget period. This is consistent with ESMV's rate. The rate may change in years 1 to 5 as NILP has a higher rate as their agency is smaller. The indirect allocation covers staffing for senior management , Human Resoures, Core IT, Finance, Billing and Legal. It also includes costs associated with that staff such as occupancy and travel.

	A	B	C	D	E	F	G
392							
393							

Community Partner Infrastructure Allocation Worksheet

	Insert Contractor Name Here						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL FUNDS AVAILABLE	$ 450,000	$ 590,625	$ 503,415	$ 327,197	$ 181,818	$ 75,257	$ 2,128,312
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Consortium Entity or Affiliated Partner	$ 200,700	$ 111,458	$ 40,500	$ 65,500	$ 65,500	$ 40,500	$ 524,158
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ 200,700	$ 111,458	$ 40,500	$ 65,500	$ 65,500	$ 40,500	$ 524,158
Workforce Development							$ -
NILP/Disability Awareness Training	$ 10,000	$ -	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 50,000
Consortium Entity or Affiliated Partner	$ 2,000	$ -	$ -	$ -	$ -	$ -	$ 2,000
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ 12,000	$ -	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 52,000
Business Start Up Costs							$ -
Consortium Entity or Affiliated Partner	$ 180,183	$ 274,699	$ 140,246	$ 82,247	$ -	$ -	$ 677,375
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ 180,183	$ 274,699	$ 140,246	$ 82,247	$ -	$ -	$ 677,375
Operational Infrastructure							$ -
NILP/Staffing	$ -	$ 95,095	$ 167,911	$ -	$ -	$ -	$ 263,006
Consortium Entity or Affiliated Partner	$ 30,016	$ 74,203	$ 35,617	$ -	$ -	$ -	$ 139,836
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ 30,016	$ 169,298	$ 203,528	$ -	$ -	$ -	$ 402,842
TOTAL INVESTMENTS	$ 422,899	$ 555,455	$ 394,274	$ 157,747	$ 75,500	$ 50,500	$ 1,656,375

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Development and Adaptation of E.H.R/Care Management System	Implement software to ensure that Day 1 contract deliverables will be met.	11/01/17	05/30/18	Core components of system are established and in testing phase	Sample data has been entered in a sandbox environment to track enrollees and engagement activities.			System is operational.	Navigators are trained and enrollees can be entered into the system. Billing files can be generated at the end of the month.		
Technology		Set up laptops for navigators to be used at point of care.	03/01/18	05/30/18	Laptop application is in testing.	Laptops are purchased and able to test eHana sandbox environment.				Navigators use laptops at the point of care for recording information.		
Technology												
Technology												
Workforce Development	Training Expenses	Develop disability awareness training to be offered by NILP	07/01/17	05/31/18	Training curriculum is established	Training occurs.				Navigators approach enrollees with inceased cultural awareness.		
Workforce Development												
Workforce Development												
Workforce Development												
Business Start Up Costs	Office Furniture	Space is configured for new staff.	02/01/18	05/01/18	Renovation of space is complete.	Space renovation is complete.			Equipment is installed. Staff are working in offices.	Staff are productive and efficient. Space and equipment distractions are minimal.		
Business Start Up Costs												
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Operation Staffing including Fringe	Key positions are hired.	10/01/17	01/01/18	All positions except navigators are in place.	Key milestones on the project plan have been met such as workflow design, ACO relationships established and roles and responsibilities are defined.			All positions in staffing plan are hired. Initital navigators are trained.	Navigators are prepared to engage enrollees on day 1.		
Operational Infrastructure		Marketing materials are produced	11/01/17	03/31/18	Materials for ACO education are produced.	ACOs are educated about MVCP.			MVCP is reflected on ESMV & NILP's websites is established.	Community can navigate to MVCP website easily and quickly.		
Operational Infrastructure												
Operational Infrastructure												

Section 7. 5 Initial DSRIP Participation Plan

A. Executive Summary

1. Goals, Challenges, and Proposed Solutions

Strategic Goals

Merrimack Valley Community Partnership (MVCP), consisting of Elder Services of the Merrimack Valley (ESMV) and Northeast Independent Living Center (NILP), working with the Northeast Community Collaborative (NCC) as a strategic network partner, affirms our commitment to EOHHS' goals for the LTSS CP program over the next five years. Our strategic goals and strategies, which are closely aligned with EOHHS's goals, are as follows:

EOHHS' Goal	MVCP's Approach
Improve collaboration across ACOs, MCOs, providers and CBOs	Expand community linkages with ACOs, providers and other community partners through our community-based coalition, NCC.
Improve Enrollee experience and quality of care; assist Enrollees in access to settings and levels of care	Invest in initiatives to increase Enrollee awareness of available services and supports. In addition, we will support educational and training initiatives to improve access to culturally and linguistically appropriate services.
Leverage ACO and MCO expertise serving LTSS needs	Collaborate with ACOs and MCOs to leverage infrastructure including connectivity. We will also educate ACOs and MCOs regarding LTSS CP services.

MVCP is fortunate to have established strong relationships with three entities that have submitted ACO applications within our identified Service Areas. All three ACO-applicants have indicated their intention to work with MVCP as an LTSS CP and have asked us to be involved in the roll-out of their ACOs if awarded.

Opportunities and Challenges

MVCP's timeline calls for rapid implementation to create complex systems, including Information Technology (IT). Educating networks, ACOs, MCOs and others will be integral to the challenge of having others appreciate the value of LTSS. We will use DSRIP funds efficiently, leveraging resources available across the ACO system. Our goal is to participate in an integrated system, eliminating silos that have historically impeded care integration.

2. Projected Assigned and Engaged Enrollees

The MVCP intends to support 1,125 Engaged Enrollees under any Contract that results from this Request for Responses (RFR) submission.

3. Service Area

The MVCP will provide LTSS CP services in the Haverhill, Lawrence and Lowell Service Areas.

4. Implementing the Plan

During 2017-2018, the MVCP will focus on implementing essential CP requirements and Enrollee-related initiatives. We will complete all Management Agreements between ESMV and NILP and with ACO and MCO partners. Over the course of the Contract, MVCP will focus our efforts on enhancing and improving: our ability to serve increasing numbers of Enrollees (e.g., capacity); the breadth and depth of our relationships with ACOs and Community-based Organizations (CBOs), leveraging our relationship with NCC; and the level of sophistication of Information Technology

(IT) tools and functions moving from a focus on pay-for-reporting to full connectivity and sharing of comprehensive assessments and Individualized Care Plans (ICPs)

B. Supporting Populations and Community Engagement

1. Service Areas

Examples of our close community-based relationships appear below. A complete list is available.

Organization Type	Service Area	Description	Nature of Collaboration/Partnership
CBOs	Haverhill	LGBT Collaborative	Provides socialization, information, and support
	Haverhill	Food Collaborative	Offer Food relief programs at housing sites
	Haverhill/Lawrence	COA,YWCA, hospitals	Provide evidence-based healthy living programs
	Lowell	Enterprise Bank	Money management education for Cambodian elders
	Lowell	Minority outreach	Coordinate services for minority populations
Advocacy groups	Haverhill	Breakfast Exchange	Support community programs
	Lawrence	Lawrence COA	Annual information and support caregiver event
		Aging and Disability Resource Consortium	Collaborative event to ensure "no wrong door" for individuals and caregivers needing access to services.
Housing/ shelter providers	Haverhill/Lawrence	Evergreen House with Emmaus;	Funded and built elder housing unit for homeless
	Lowell	Housing partnership	Built affordable and supportive housing in Chelmsford, Westford, and Tewksbury

2. Growing Community Connections

We have meaningful relationships within each local community that we serve. ESMV holds monthly Provider Network meetings across the Merrimack Valley, offering speakers on topics of interest, the chance to highlight new programs/services, opportunities to network and deepen connections with ESMV and each other. We will broaden our community connections beyond the aging services network by inviting disability organizations involved in providing LTSS, agencies serving children and youth, health care providers and BH providers, to attend meetings and/or join our extended network.

ESMV is fortunate to share the same building in Lawrence with local offices of many of the state agencies that serve the populations targeted by the LTSS CP RFR. In the past, ESMV had convened professionals who served multiple populations to discuss individual cases, share information on resources, identify options and facilitate collaboration. We see great value in bringing together this kind of group as an LTSS CP for the Merrimack Valley.

Another key component of our success is the Northeast Community Collaborative (NCC), formed by ESMV and NILP in 2016. ESMV and NILP brought 20+ providers, as well as potential Accountable Care Organizations (ACOs), Managed Care Organizations (MCOs) and Community-based Organizations (CBOs) together to share expertise and innovative approaches, identify and confront common challenges faced by entities involved in LTSS and to offer ongoing guidance to the MVCP. NCC members deliver a significant volume of LTSS and other services that impact social determinants of health in the Merrimack Valley. The NCC will have a voice in the LTSS CP through ongoing participation in service delivery and will have a voting member on the MVCP Governing Body as described in **Section 7.2 C**.

Link to Business Plan: There are multiple linkages between ESMV's and NILP's plans to enhance the breadth and depth of our community connections and our business plan: Under our business plan, we will focus on IT connectivity with ACOs and MCOs in our Service Areas. We also hope to increase overall connectivity with CBOs in year 2, as these relationships will increase in number in Year 1.

3. Updating Community Resource Information

We will inform and update staff on available resources in several ways:

Community resource information: ESMV's Information and Resource Department has one FTE devoted exclusively to resource development and management of information for all staff. In addition to the Green Book, a comprehensive resource guide developed by ESMV and NILP, we also maintain a database and resource library. ESMV will maintain these resources. NILP will collaborate with ESMV to develop, update and distribute information. **Section 7.5.K 1** includes additional information about NILP's Training and Learning Collaborative.

Staff training: We will organize and conduct ongoing educational sessions for staff to support collaboration with CBOs including community resource information and staff orientation updates as well as staff conferences, guest speakers, and community events.

Interdisciplinary care team meetings: The care team will review the community resources included in each Enrollee's LTSS Care Plan and review additional community resources as needed.

Website updates/newsletters: The MVCP will develop and issue electronic information updates to ACOS, MCOs, CBOs and other stakeholders.

C. Community Partner Supports and Activities

1. Enrollee Outreach

ESMV and NILP employ all available resources to truly engage individuals where they are – physically, emotionally, linguistically and otherwise. Our approach begins with learning about how individuals define their needs, which is critical to the process of building rapport and trust. Key outreach strategies are as follows:

We meet the Enrollee at a location of their choosing. The location may include, but not be limited to, the Enrollee's home, neighborhood locations, homeless encampments, motels, shelters, or congregate meal sites among other locations. MVCP will deploy Point of Care (POC) Navigators who will be embedded in hospitals or other health care facilities. The POC Navigator or a "field" Navigator will initiate contact with referred Enrollees wherever they are located or choose to meet. We will truly connect with the Enrollee and build trust. If a contact is not made after multiple attempts, we will reach out to shelters and/or BH providers and other CBOs.

The relationship between Enrollee and our staff is primary. We begin by listening to the Enrollee and engaging them with respect. We create an open, safe, friendly environment in which to meet and immediately focus on the Enrollee's basic needs.

We hire highly qualified, skilled individuals who are trained in motivational interviewing and coaching and are very skillful in interacting with individuals with complex LTSS needs. Our staff are passionate about serving the target population and understand their needs and preferences.

Engagement Process

Effective engagement will begin with the Enrollees' first MVCP contact: the POC Navigator. The Administrative/Intake Coordinator will schedule the first in-person contact with LTSS CP-eligible Enrollees. Navigators, employed by ESMV and NILP, will follow up to reach out to, and connect with, Enrollees wherever they are located. We will adapt outreach protocols from current processes that our outreach teams use today within ESMV's Care Transitions program. We have produced successful results establishing contact and engaging individuals, including those who are homeless, with complex medical and BH challenges.

Engagement and Enrollment Specialists will also participate in the engagement process and focus on those enrollees that are identified as highest risk. These specialists are clinically trained to work with high risk individuals that may be reluctant to enroll in the MVCP program and resistant to care. The specialist participates in outreach activities that allows for direct engagement with potential consumers where they live. This includes establishing good relationships with service organizations like shelters or mental health clinics or soup kitchens; as well as local contact with police and public officials who may be aware where these individuals reside. This specialized attention helps establish the trust and good will needed to encourage someone to participate. Specialists are trained to "work through" someone's resistance or denial to get them enrolled; and then provide encouragement and support once a person becomes an enrollee. These specialists will also provide follow up with consumers who refused help, and work to arrange another CP-LTSS provider if someone doesn't want our services. Once engaged, the consumers would transition to Navigators for ongoing LTSS care coordination.

Outreach may involve seeing Enrollees during an acute care event at a local hospital if the Enrollee is comfortable meeting at that time. We maintain communication and interaction protocols including notification to POC Navigators of an Enrollees' admission or Emergency Department (ED) registration at service area hospitals. In the ED, and during inpatient stays, POC Navigators will partner with hospital-based case managers to improve care plan consistency, while eliminating duplication of effort and confusion for Enrollees. Our POC Navigator will participate in discharge planning; a Navigator will follow-up on transitions to reduce the likelihood of readmission. This innovative approach allows the POC Navigator to partner with hospital care managers to engage the Enrollee, reducing avoidable high-cost services.

During the first in-person contact, the POC Navigator will focus on understanding the individual's needs, their health status and their hopes and/or frustrations with their current situation in a culturally and linguistically appropriate manner. Once the Enrollee feels heard, MCVP will utilize motivational interviewing techniques, and the POC Navigator will explain how LTSS CP services can help address the Enrollee's defined needs and preferences. Our POC Navigators will listen actively, respond to the individual's questions and concerns to overcome barriers to care and help create a support network for the Enrollee. MVCP will provide information regarding our service delivery process with attention to the individual's preferred way of engaging with our organization. We will provide Enrollees with detailed information regarding how to reach their primary Navigator.

The Navigator will explain the anticipated frequency and options available for CP service delivery and will meet with the Enrollee at a place and time that is most comfortable for the individual and their family member or caregiver if appropriate. If agreed to by the Enrollee, MVCP believes that home visits are preferable as they can provide insight into social determinants of health and home

safety. Some Enrollees may be difficult to reach; meeting them where they are increases the likelihood of success.

Ideally, the individual who performs the initial contact and assessment would serve as the Enrollee's Navigator. Due to the volume of referrals, this may not be possible. When necessary, the POC Navigator will make a "warm transfer" to a Navigator as soon in the engagement process as possible. If a better match exists, or if the Enrollee prefers a different Navigator, another MVCP staff member will be assigned. Our Navigator will explain that the Enrollee can opt out of receiving CP services at any time. Enrollees will also be able to request assignment to a different LTSS CP organization at any point in time.

Individuals who choose not to enroll will be provided with contact information should they choose to enroll later, and will be asked if periodic outreach from a Navigator is acceptable.

2. LTSS Care Planning

a. Ensuring Enrollee Meaningful Participation in Care Planning

The MVCP will incorporate Comprehensive Assessment data from the ACO or MCO to which the Enrollee belongs, combined with the full involvement of the enrollee in making their needs and preferences known. We will also review available medical records information and other relevant data.

Using all available information, MVCP POC Navigators and Navigators will develop a person-centered LTSS Care Plan. We will fully involve the Enrollee in the development and management of the LTSS Care Plan through care planning meetings and telephonic contract. We place the Enrollee at the center of their LTSS Care Plan process in order to ensure that the Enrollee participates in the LTSS Care Plan development in a meaningful manner.

b. Providing Informed Choice

Throughout the care planning process, staff will talk with Enrollees about options and the best resources to meet their needs, as they define them. MVCP will listen to the Enrollee and make sure they and their family/caregiver have a full understanding of the benefits and services available to meet the needs they have identified. Then we will actively involve the Enrollee in selecting optimal services and supports. Our goal is to help the Enrollee advocate for their own well-being and health.

The Enrollee's LTSS Care Plan will be designed with the primary goal of meeting the individual's defined needs and preferences. If the Enrollee wishes to remain in or return to the community independently, we will support their desire to live in the least restrictive environment. We will arrange services and supports to maintain, and where possible, extend the function and maximize independence. Enrollees will always be encouraged to be as independent as possible, both in performing Activities of Daily Living and Instrumental Activities of Daily Living, and in choosing and arranging for the programs, services, and resources they utilize to assist with those activities.

We will train staff to provide unbiased information about LTSS and resources to help the Enrollee determine the next steps to take while ensuring that the Enrollee maintains control over the process. We will work in concert with community-based partners to provide Enrollees with efficient access to LTSS for people regardless of age, income or disability.

We will support consumer choice and assist Enrollees with the selection of LTSS contracted providers; if the individual wishes to maintain existing relationships, we will arrange services with that provider where possible. If the Enrollee wishes to select a different provider, we will arrange such a change. As is our current practice, all Enrollee complaints regarding contracted service providers are taken seriously and will be thoroughly investigated to ensure satisfactory resolution.

3. Care Team Participation

a. Promoting Integration of LTSS Communication

ESMV and NILP are aware that the success of the LTSS CP program relies on our shared ability to coordinate care across stakeholders. We believe that Enrollees will be best served through the sharing of complete, up-to-date integrated Enrollee information across organizations, including state agencies and CBOs. Such sharing of information is crucial to the delivery of integrated care coordination and represents an opportunity to achieve savings on infrastructure and IT resources. At the outset, we will a have a compliant, functioning solution that supports care integration; however, over time, our desire is to have a fully interoperable system capable of supporting shared assessments, care plans, reporting and quality management functions. We currently collaborate with ACO and MCO partners in our service area and will do everything possible to support such collaboration. We are also seeking to purchase a care management platform that has interoperable functionality with ACOs.

ESMV and NILP will leverage current and future tools based on the selected IT vendor's technology platform to support effective communication across all stakeholders, including support for the exchange of essential documentation to effectively coordinate care.

Information Sharing & Interoperability. The MVCP intends to leverage standardized technology frameworks to facilitate data exchange with EOHHS, ACOs, MCOs, and other stakeholders. MVCP's IT vendor (eHana)'s Meaningful Use-certified EHR provides validated support for healthcare interoperability standards and standardized transactions formats. We recognize that specific infrastructure and technology investments will be necessary to support the information sharing requirements of EOHHS and ACOs fully, include bespoke/custom extracts and integrations. Our IT solution is further described in **Section 7.4** of this RFR submission.

b. Providing LTSS Expertise on Care Teams

ESMV and NILP will connect each Enrollee to appropriate services by actively collaborating with ACO, MCO, physical, BH and social service providers based on the Enrollee's needs as they define them. When possible, MVCP will participate on the Enrollees' care teams (e.g., ACO, MCO, BH Community Partner), acting as a knowledgeable resource regarding hearing the importance of providers' ability to hear the Enrollee's voice and, regarding LTSS.

As part of the ongoing care delivery process, we will educate service providers on the unique needs of Enrollees with LTSS needs, LTSS services and supports, eligibility criteria, and how to access available benefits. We interact with, and educate, providers as a routine part of our care planning process.

4. LTSS Care Coordination

a. Monitoring and Managing the Member's Status

The MVCP will monitor and manage the member's status and life events using existing care coordination processes which will include:

- Conducting comprehensive assessments and reassessments of the Enrollee's strengths and needs
- Facilitating Enrollee-driven treatment planning with the interdisciplinary care team to develop an individual LTSS Care Plan
- Coordinating care across all systems and providers serving the Enrollee by sharing critical information (inpatient admissions, medications) and facilitating communication (participating in meetings, making telephone calls)

- Identifying if the Enrollee has had appropriate preventive (medical) care and making referrals for treatment
- Contacting the Enrollees Primary Care Provider (PCP) to coordinate care
- Meeting with the Enrollee when their condition changes (e.g., the visit the ED multiple times, they experience an inpatient admission, they lose a caregiver, or they become homeless) to reassess their level of need
- Addressing barriers to care, such as transportation
- Linking the Enrollee to community-based resources and social supports (housing, food, benefits)
- Assessing the Enrollee's progress toward treatment goals and coordinating with the Enrollee and the interdisciplinary care team to update the Person-Centered Treatment Plan generally and the LTSS Care Plan specifically
- Supporting Enrollees during transitions between levels of care

As community-based service providers, the MVCP is well-positioned to continue providing care coordination to Enrollees with complex LTSS needs. Through our relationships with ACOs, MCOs, providers, and CBOs, we will readily coordinate care and facilitate Enrollee access to services.

b. Supporting Enrollee's Ongoing Engagement in Care

All Enrollees will be approached with respect, sensitivity to their beliefs and cultural heritage, and a sincere desire to understand what they want for themselves. We seek to build trust while recognizing the impact of trauma, stigma, and discrimination that many of our consumers have experienced. Our Navigators will be trained to listen to the Enrollee's perspectives and beliefs actively, and to ask questions to understand their impact on his/her choices fully. During each interaction, the Navigator will work to develop a trusting relationship with the Enrollee to enable him/her to ask questions and share honest opinions. MVCP staff will receive training in disability awareness, cultural competency, strategies for enhancing Enrollee engagement in the treatment process, self-identification of goals, and engagement in opportunities that promote recovery and resiliency.

To further promote Enrollee engagement, LTSS Care Plans are designed to focus on each Enrollee's life goals while incorporating his/her strengths, preferences, and needs into the LTSS Care Plan in a culturally and linguistically appropriate manner. Treatment services are individualized to meet each Enrollee's and their family's needs, preferences, and capabilities.

5. Transitions in Care

The MVCP brings a wealth of experience in managing transitions in care. We will leverage our effective processes to provide Enrollees with informed choices, ensure supports are in place to enable successful transitions in care, and ensure Enrollee's stability and satisfaction post-transition.

a. Enabling Successful Transitions

Providing Informed Choice. ESMV provides Transitional Care Coordination which includes a focus on the social determinants of health. We will provide a choice of multiple service options with at least two providers per service option based on Enrollee needs and preferences. NILP and its NERLC offer Peer Support and Peer Bridgers who assist consumers in their transitions from hospital/institution to home including the development of a Wellness Recovery Action Plan (WRAP), an evidence-based approach that facilitates self-determination and empowerment and clearly expresses how the consumer wishes to be supported in recovery.

Ensuring Supports are in Place. As part of the transition process, an MVCP Navigator will coordinate across disciplines to meet the consumer's identified needs and develop a transition plan

to ensure the Enrollee receives the support needed for a successful transition. At a minimum, the MVCP Navigator will:

- Participate in discharge/transition planning with the Enrollee, facility, and providers
- Contact the Enrollee to hear their needs, complete an assessment and update their LTSS Care Plan to reflect their status
- Educate the Enrollee on available services and supports to assist them in transitioning to the community
- Contact the Enrollee's PCP to coordinate discharge planning and follow-up services
- Update the Enrollee's LTSS Care Plan in coordination with the Enrollee and their interdisciplinary care team
- Make referrals for services delivered by other systems (medical care)
- Connect the Enrollee to community-based supports

b. Ensuring Enrollee's Stability and Satisfaction Post-Transition

The Navigator will contact the Enrollee within three business days of discharge to identify their needs and update the LTSS Care Plan to provide transitional care support. The MVCP Navigator will further coordinate the Enrollee's LTSS needs, according to LTSS CP Model Contract requirements. The Navigator will: conduct regular and ongoing follow-up based on the Enrollee's needs; make sure they are receiving all needed services; assess progress toward treatment goals; and, determine the need to update the LTSS Care Plan. The Navigator will also facilitate communication between the interdisciplinary team to ensure care coordination of medical, BH, psychosocial and LTSS care and supports.

6. Health and Wellness Coaching

The MVCP will provide health and wellness coaching as directed by the Enrollee's care team and as detailed in the Enrollee's Care Plan. Navigators will have access to an array of evidence-based health and wellness programs offered through ESMV's Healthy Living Center of Excellence (HLCE) and NILP. The HLCE represents a unique statewide collaboration of community-based organizations, aging service providers, health care systems, government agencies, and health care payors. This nationally recognized Center strives to promote good health and independence for participants by offering 14 evidence-based health programs that address individual health issues and empowers patients to be better health care advocates and consumers. See also: www.healthyliving4me.org.

NILP offers consumer-directed education to empower consumers to take better care of their health and focus on wellness including but not limited to:

- Wellness Recovery Action Planning (WRAP): A 10-week training session where WRAP participants learn how to create a self-designed plan for maintaining an overall sense of wellness, ways of overcoming feelings of un-wellness, improve their quality of life, focus on recovery and lasting well-being.

- Whole Health Action Management (WHAM): Peer Support Training developed by the SAMHSA/HRSA Center for Integrated Health Solutions (CIHS). The primary goal of this training is to teach skills to better self-manage chronic physical health conditions, and mental illnesses and addictions (BH) to achieve whole health. In the context of this training, whole health is defined as having a healthy mind and body. This evidence-based educational and support program is now being used by trained peers in MA to help other peers to identify

what wellness goals are important to them, and with support, to develop action plans for reaching those goals.

7. Connecting Enrollees to Social Services

a. Evaluating Enrollee Social Service Needs

In our current practice, ESMV uses the CDS assessment tool and NILP uses the Independent Living Service Plan (ILSP). Both have elements that assess social service needs. In addition, we have developed risk management tools related to social determinants specific to the health care partners with whom we were engaged. We plan to work with ACO's to review these and other tools they may suggest to determine which tools are best.

b. Ensuring Ongoing Connections to Community Resources and Social Services

The MVCP will jointly develop processes and procedures with ACOs in our Service Areas to collaborate and coordinate the delivery of Flexible Supports authorized by the ACO. LTSS CP Navigators will work with ACO Care Managers for Engaged Enrollees to identify such supports (as documented and authorized by the ACO) and jointly establish a plan for providing or arranging for them (as appropriate).

The MVCP has longstanding existing relationships with community and social service agencies in our service area. We will leverage our relationships within and outside the NCC, e.g., school systems, to ensure the broadest access possible to needed supports and Flexible Supports. We will build upon existing referral and coordination processes to facilitate ongoing communication with both Enrollees and providers and ensure that Enrollees have timely access to needed community supports. Our formal current and planned approach includes:

- Developing comprehensive referral and community resource guides for Engaged Enrollees and CP staff
- Appointing dedicated Point of Care Navigators
- Executing memoranda of understanding with providers and community organizations regarding the delivery and coordination of services

Through our care coordination processes, MVCP staff will follow up with all providers, systems, and organizations to make sure the Enrollee receives all services and supports in accordance with the LTSS Care Plan.

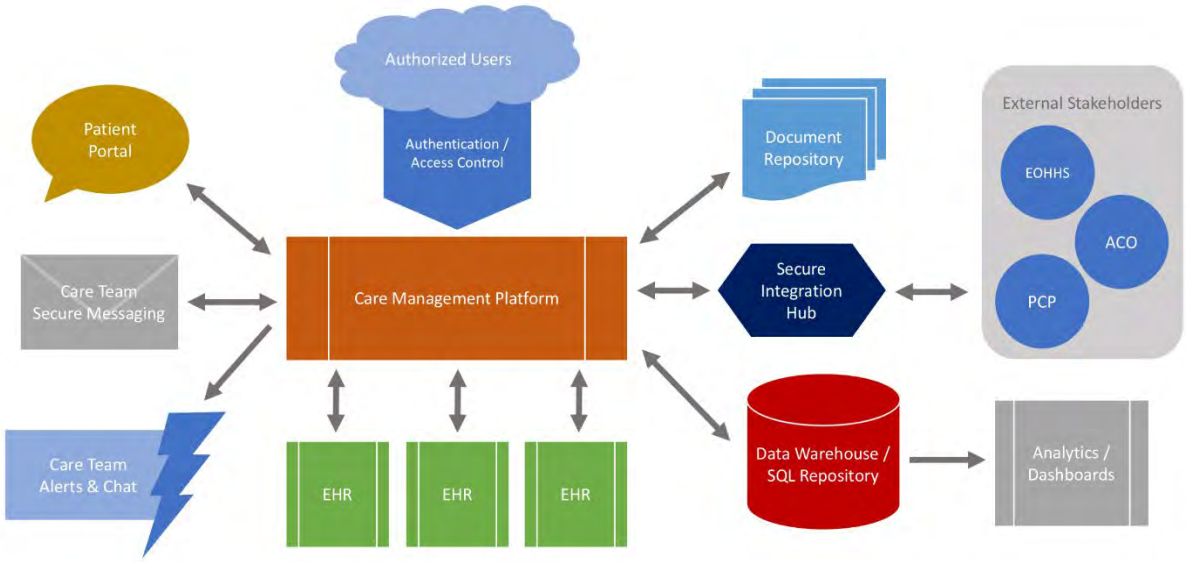
D. Innovative Technologies for Service Delivery

Community Partner Program Requirements

The MVCP intends to partner with an IT organization, eHana, to deploy Care Coordination/Care Management platform technology to meet the various requirements of the LTSS CP program.

Below, the MVCP offers a conceptual diagram that illustrates how we hope to use technology to ultimate meet the LTSS CP IT requirements. Following is a description of our innovative approach to service delivery; our goal is to finalize plans with eHana and produce the functionality illustrated below early in the implementation period of any Contract that may result from this RFR submission.

The overall innovative system that we hope to create can be depicted as follows:



Architecture diagram (simplified)

MVCP will work closely with the selected vendor to develop forms, workflows, processes, reports, and data extracts that meet or exceed the compliance requirements of the Community Partner program, including:

- Storing assessment data
- Documenting Care Plans
- Tracking enrollee assignment, engagement, disengagement, and overall capacity
- Capturing appropriate signatures and document approvals per EOHHS requirements in the timeframes specified
- Surfacing alerts, reminders, and tasks as necessary to prompt Care Team action
- Tracking enrollee events, admissions, referrals, and prompting for necessary follow-up
- Tracking, reporting, and billing appropriate Qualifying Activities to EOHHS in formats specified

Care Coordination

The MVCP will leverage current and future tools based on eHana's technology platform to support effective communication across all stakeholders, including support for the exchange of essential documentation that will allow for optimal care coordination. Our goal is to share assessment and care plan data as essential integrated care tools.

Information Sharing & Interoperability

MVCP will leverage standardized technology frameworks to facilitate data exchange with EOHHS, ACOs, MCOs, and other stakeholders. IT vendor's Meaningful Use-certified EHR provides validated support for healthcare interoperability standards and standardized transactions formats. MVCP also recognizes that specific infrastructure and technology investments will be necessary to support the information sharing requirements of EOHHS and ACOs fully, including bespoke/custom extracts and integrations. By way of example, IT vendor technology is currently capable of producing and transmitting CCD files, querying EOHHS eligibility data, and submitting structured outcomes reports to EOHHS DMH.

Technologies to be used to support care management include: Standards-based transactions including CCD over Mass HIway/Direct Project; Importing eligibility files and enrollment rosters from EOHHS and ACOs; Bespoke reporting and data extracts in formats specified by EOHHS and ACO partners; Standardized HIPAA billing transactions (837p) of Qualifying Activities to EOHHS; Future use of EOHHS Event Notification System (ENS) or, where possible, event data integration directly with healthcare stakeholders.

The MVCP will also use innovative technologies including lightweight laptops, cell phones, and real-time notification systems (e.g., to obtain notification of Emergency Department [ED] or hospital use).

E. Personnel and Staffing

1. Organizational Chart

An organization chart is included in this RFR submission as **Attachment 7.5 E 1**.

The MVCP staffing model will be comprised of a Program Director, Program Managers, an Enrollment and Engagement Manager, Navigators and Point of Care (POC) Navigators, Enrollment and Engagement Specialists, an Admin/Intake Coordinator and a Quality/Data Manager. POC Navigators and Navigators, as well as the engagement and enrollment specialists will meet with Assigned Enrollees at their location of choice, e.g., home, skilled nursing facility or any other location of the Enrollee's choosing.

The Enrollment and Engagement Manager will work with the LTSS-CP team and management staff to help establish effective working relationships with Accountable Care Organizations. These activities will help ensure consumer enrollment and engagement activities are well established in the first year of operations. This includes development and distribution of marketing and education materials and outreach activities with potential partners and ACO principles. The Enrollment and Engagement Manager would also play a key role in providing education to PCP's and other members of the enrollee care team on the role of MVCP, and how the navigator impacts care planning and implementation for both the care team and the ACO enrollees that are referred.

Enrollment and Engagement Specialists will work on engaging those members considered at highest risk. All Navigators will perform contractual Outreach requirements by informing the Assigned Enrollee of the option to receive LTSS CP Supports and the benefits and process for enrolling in the LTSS CP program. The POC Navigator will participate in the discharge-planning process, helping create a smooth transition home with appropriate services and supports. Both POC Navigators and Navigators will be responsible for explaining the Protected Information (PI) that MVCP requires in order to provide LTSS CP services. After explaining the program and PI, the POC Navigator will obtain the signed LTSS CP Participation Form from the Assigned Enrollee, confirming their interest in participating in the LTSS CP program. The signed Participation Form will be stored in the Enrollee's record. MVCP will obtain written authorization to disclose PI to the extent required.

Within five business days of receiving the signed Participation Form, MVCP will assign the now Engaged Enrollee a Navigator who best matches the Enrollee's cultural and linguistic needs. The Enrollee's Navigator will then initiate LTSS Care Planning.

MVCP will have teams consisting of an Enrollment and Engagement Specialist, two Navigators and two POC Navigators. These staff will report to the Program Managers. Based on anticipated

volume, we are preparing to staff three teams, two Program Managers and an Enrollment and Engagement Manager. The Enrollment and Engagement Manager will be a 1.0 FTE. Each Program Manager will be a .5 FTE employee. ESMV and NILP will employ the Navigators, POC Navigators, the Enrollment and Engagement Specialists, the Program Managers and the Enrollment and Engagement Manager. A Program Director will have oversight of the program and will be a 1.0 FTE employee of ESMV. A Quality/Data Manager and Administrative/Intake Coordinator will round out the staffing for our LTSS CP.

2. Staffing Model for Proposed Engaged Enrollees

We propose serving 1,125 LTSS CP eligible Enrollees across the three Service Areas, as described in **Attachment D**. Our staffing model will include the following positions and number of full-time equivalents (FTEs). Job descriptions are provided as **Attachments 7.5. E-3 A-F**.

Table 7. 3. E. 2. Staffing Model

Positions	FTEs
Program Director	1.0
Program Managers	1.0
Enrollment and Engagement Manager	1.0
Enrollment and Engagement Specialists	3.0
Point of Care Navigators	6.0
Navigators	7.0
Quality/Data Manager	1.0
Admin/Intake Coordinator.	1.0
TOTAL	21.0

3. Recruitment Plans

We will begin the recruitment process for key positions once we have received a signed contract. ESMV and NILP are equal employment opportunity organizations that are committed to providing equal treatment for all who seek opportunities for employment or advancement. All qualified applicants receive consideration for employment without regard to race, color, religion, creed, sex (including pregnancy), sexual orientation, national origin, ancestry, age, or disability/handicap, genetic information, veteran status, National Guard or reserve unit obligations or other protected status.

All job announcements are posted internally, as well as on our websites and sent out electronically for placement on a variety of external job boards including indeed.com. This allows for as much exposure as possible. Positions are analyzed prior to posting to ensure that any cultural and linguistic backgrounds needed are requested in the posting; providing a base of competent staff who can support the needs of the communities within the areas we serve.

Both ESMV and NILP provide generous benefits including significant contributions to medical and dental plans. Both organizations offer a 403(b)-retirement plan and generous paid time off for personal time, sick time and vacation time for full and part-time employees.

4. Recruitment and Hiring from Culturally and Linguistically Appropriate Communities

We will maintain and enhance our visibility within the minority community - this allows us to be "seen" and known within a minority community and meet potential staff for future employment.

- We have formal outreach programs to reach minority communities in the Merrimack Valley (particularly Asian, Latino and Portuguese communities).
- We establish working relationships with agencies or organizations that work directly with minority populations.
- We provide specialized services geared to minority populations. Two examples; a Cambodian Money Management workshop offered in Khmer; a Latino caregiver event annually in collaboration with the Lawrence Council on Aging.
- We are a primary sponsor and often attend events hosted specific to a minority population or community. This generally allows us some free advertising – an ability to network or to display information about the agency or a specific program or need.

We currently serve a large minority population particularly in the Lawrence and Lowell areas and have long had a concerted effort to recruit bilingual/bicultural staff members. Currently, our language capacity as an agency includes 27 different languages. These staffs serve as a gateway for recruiting and hiring other bilingual and bicultural staff. This is a real advantage to our efforts for diversity, as they often are the catalyst for finding staff with ability and sensitivity to a variety of cultures and languages.

We advertise in several different media that include diverse languages and cultures. (e.g., Rumbo, a Spanish weekly newspaper in Lawrence). We have established contracts with SCOs and service providers who also have bilingual-bicultural staff. It is not unusual for recruitment between agencies to occur. We attend minority outreach job fairs and participate in local civic events (including political advocacy events and chamber of commerce activities) to reach a larger population.

5. Staff Training

The goal of our training programs will be to provide MVCP staff with an understanding and awareness of the issues facing individuals with complex LTSS needs, understanding CP supports, social services and supports available in the community, disability awareness and delivery of culturally competent care. We will train our LTSS CP Team and other key staff on these topics and will leverage existing training modules to develop comprehensive CP training. Refresher training, as well as updated training on best practices, will occur at least annually. We will finalize training modules and training schedules prior to the contract effective date. Below are examples of our current training programs:

- Cultural competency – we have provided numerous cultural diversity training in the agency as well as established a cultural diversity council for us to determine the best systems, training and staff to support minority outreach and casework activities. This includes cultural diversity and LGBTQIA training. NILP's Training & Learning Collaborative (described in **Section 7.5 K 1**) offers an entire training module on Disability Awareness and Cultural Competence, which all MVCP staff will complete. In training, both ESMV and NILP will emphasize communication and cultural competence with diverse experiences, belief systems, and cultures. NILP's Training and Learning Collaborative (TLC) offers extensive training in Disability Awareness and Cultural Competence. TLC's core curriculum addresses: History, Philosophy & Consumer Direction; ADA and Cultural Competence – Beyond Compliance to the Real Spirit of the Law; Diverse

Experiences and Cultures within the Disability Community; Cultural Competency in diverse cross-disability populations including Enrollee self-determination and autonomy in the Integrated Care Team.

- Accessibility and accommodations – we have a formal in-service department that provides clinical in-services once a month for all field staff. This has included information about low vision needs, accessibility and disability rights, durable medical equipment and assistive technology, dementia simulation and adaptation, and home environment training for those with vision and/or memory issues.
- Independent Living and Recovery Principles - Cross-training is already planned for this spring with NILP's Training & Learning Collaborative to enhance ESMV's understanding of disability issues and independent living and recovery principles, which we plan to continue. These principles can be reinforced in group supervision with Navigators. ESMV has a state-of-the-art training center that accommodates large groups to participate in training.
- Motivational interviewing – This course has already been developed at ESMV and is offered annually to staff to ensure all are trained in motivational interviewing techniques.
- Conflicts of interest, and mitigation strategy for conflicts of interest-
  - a. ESMV has an established Conflict of Interest policy and practice; all employees are trained in and must comply with this policy, which includes clear protocols for mitigation activities.
  - b. We have an established ethics committee that includes members of our Board of Directors to ensure our practice is sound and ethical.
  - c. We have a full-time attorney on staff who works directly with community care programs and can provide advice, counsel, and training on conflicts of interest and mitigation issues. ESMV also consults with attorneys outside of our agency in our protective service and crisis work to ensure the standards of our efforts.
  - D. Health and Wellness principles- we established the Healthy Living Center of Excellence at ESMV over 10 years ago, offering 14 different evidence-based health programs to over 20,000 participants statewide. This center has served as a national model for operating health and wellness programs that address the basics of preventive care, patient empowerment, and good chronic disease management practice. Programs are offered in both Spanish and English. NILP's NERLC also offers evidence-based health and wellness programs such as WRAP and WHAM which promote consumer empowerment.
- For LTSS CP Navigators and Program Managers:
  - Person-centered planning processes – using a curriculum approved by EOHHS and developed by Boston University. Within our training, orientation, and group supervisory practice there are numerous opportunities for training on person-centered planning processes. The curriculum was developed based on EOEA's standards as well as national and state practice in both the disability and aging fields. NILP's Options Counselors also participated in this training.
  - MassHealth state plan and LTSS eligibility criteria – our staff orientation and training program includes information about MassHealth LTSS eligibility practice and criteria. MassHealth consultants are available to consult with ESMV and NILP staff on an every other week basis.
- We have established training and workshops for various clinical initiatives and have been involved in both national and state presentations on subjects including suicide prevention, brain injury, homelessness, abuse and neglect, hoarding, Alzheimer and related dementias, depression,

risk management processes and protocols, and financial fraud and abuse interventions. Training in each of these topics can enhance the basic core knowledge of Navigators and be provided in tandem with other training opportunities.

- The NCC also offers considerable knowledge and expertise for staff who want to understand both the disability and aging support and service networks.

We will seek to partner with ACOs and MCOs to hold periodic conferences for Enrollees, staff, Care Navigators, BH-CPs, social service and community agencies to which Subject Matter Experts (including experts from the ACOs, MCOs, and ILCs) will be invited as speakers.

Staff training will be facilitated by making work hours available for staff to participate on a mandatory basis; and tracking participation electronically through a learning management system (LMS); enabling online evaluations and scoring; providing resource guides and training materials to reinforce learning.

Whenever possible, we will work with ACOs and MCO to develop and deliver training on topics of mutual and common interest, such as care coordination strategies, community collaboration and cultural competence. We will leverage existing MassHealth training and resources into staff training and material, encourage MassHealth training forum attendance and ensure staff interacting with Enrollees with LTSS needs complete required training on LTSS competencies.

6. Retention Strategy

ESMV and NILP maintain an organizational culture and environment that respects and supports a committed workforce through a combination of flexibility and benefits. In addition to competitive salaries and generous benefit packages, ESMV and NILP provide ongoing training and CEU opportunities for their professional staff. ESMV's Social Worker Licensing Program also provides free supervision to employees both before and after licensing, test preparation, reimbursement for testing costs, and an incentive pay increase after one year license. NILP offers tuition reimbursement for eligible employees who wish to take job-related courses. Additionally, ESMV has been voted one of the Top 100 Places to Work by the Boston Globe for three consecutive years and boasts several employees with 30+ years of service at the agency.

F. Implementation Plan and Timeline

MVCP's Implementation Plan and Timeline is presented in **Attachment 7.5 F 1**:

G. Budget Report and Budget Narrative

MVCP's Budget Report and Narrative is presented in **Attachment 7.5 G-1 Attachment B** and **Attachment 7.5 G-2 Attachment C**.

H. Sustainability

ESMV has been able to successfully sustain programs and initiatives such as its Community Care Transitions Program, initially funded by CMS, by leveraging its strong partnerships with local hospitals and contracts with SCOs and other health care providers to secure new payers for our services. We plan to utilize these and other approaches to develop a sustainable foundation for LTSS CP services.

Specifically, the MVCP will sustainably fund the proposed infrastructure and capacity-building investments and LTSS CP supports during the Contract Term and following the initial Contract Term through:

- DSRIP Dollars (initial investment and ongoing funds distribution associated with volume

- Shared savings initiatives developed over time with the ACOs/MCOs
- The ability to sell services to MCOs for non-CP eligible individuals who can benefit from CP services to manage the Total Cost of Care (TCOC)for more Enrollees
- Managing fixed costs associated with IT, licensing, fees and general expenditures over time
- Identifying and developing new services for ACO, MCO and commercially enrolled individuals that support consumers remaining independent in the community and decrease TCOC associated with avoidable hospital utilization.

I. Quality Management and Performance Monitoring

1. Quality Improvement Program Description

The MVCP will create a Quality Management and Quality Improvement (QM/QI) Program. Our QM/QI program, which will support our mission, will measure and improve: clinical quality of care; care coordination; access and availability; continuity; and Member experience. Through our QM/QI program, we will apply a data-driven, evidence-based approach to service delivery and analyze and compare data against internal, local, and state benchmarks to identify opportunities for improvement. Our QM/QI program will establish goals, processes, and include an interdisciplinary committee structure.

ESMV has successfully implemented a PDSA (Plan, Do, Study, Act) Cycle quality improvement initiative. This program examined how medical information was shared between ESMV and Lowell General Hospital. Based on these findings, a streamlined transition of care record was established and shared through the health information exchange to ESMV.

Applying Principles of Continuous Quality Improvement

The MVCP's QM/QI Program will be based on continuous monitoring of quality performance measure indicators, clinical practice guidelines and other QM/QI activities. Our goal is to deliver quality care that helps Enrollees maintain and improve health and wellness. Our objectives are to: improve clinical quality; improve coordination of care; improve access to services; and, enhance all aspects of the Enrollee experience. We will achieve our goal and objectives by relying on data-driven decision making, evidence-based practices, and expert advice – all of which will be used to drive improvement. These goals will form the basis of our QM/QI program and provide areas of focus that drive our improvement strategies. We will work to improve care continuously by:

- Using data to identify and address anomalies in care and outcomes
- Developing interventions to ensure that goals are achieved
- Completing objective measurement processes and implementing improvement initiatives

The information used for quality monitoring and improvement derives from several sources including but not limited to: medical record review, consumer and/or provider feedback, utilization review, and survey data.

The QM/QI Program will define clear assignment of roles and responsibilities to each affiliated partner; performance benchmarks in alignment with program goals and contractual requirements; and Enrollee satisfaction measures. Using a continuous quality improvement approach, we will compare our outcome results to prior year results to assess our performance in meeting goals, and advance performance by establishing outcome objectives for the next year.

QM/QI Plan

Our QM/QI Plan and Annual Work Plan will constitute the blueprint for all quality goals and describe the activities that the MVCP will undertake to address all contractual QM/QI requirements.

As outlined in the QM/QI Plan, we will collect and analyze qualitative and quantitative data to drive quality improvement initiatives. The QM/QI Plan will be a responsive, dynamic document and we will continually update it based on stakeholder input and data analysis. The MVCP will also maintain an Annual Quality Workplan that delineates a core set of performance metrics and is updated based on the annual review of systems. The Work Plan will define strategies to address priorities outlined in the QM/QI Plan.

Annually, the MVCP will conduct a comprehensive program assessment that examines QM/QI program effectiveness, service utilization, cost, quality data, the prior year's outcomes, and compliance with contractual requirements. Progress toward goals will be reported to the Quality Committee, which will determine opportunities for improvement, design interventions, and track the effectiveness of interventions. In this way, we will ensure our QM/QI program is relevant to the population we serve and results in better Enrollee care.

2. Proposed QM Initiative

The MVCP is committed to improving Enrollee care by enhancing the quality of services we provide. To that end, we propose to implement a quality initiative related to enhancing Care Coordination for high-cost, high-risk Enrollees served by the MassHealth program. Specifically, as described below, we plan to implement an initiative that seeks to increase the number of Interdisciplinary Care Team (ICT) meetings in which the LTSS actively participates to create a single Interdisciplinary Care Plan (ICP) in collaboration with the ACO.

Description: The MVCP will establish a protocol with each ACO in our geographic service area designed to promote the creation of a single ICP that includes LTSS for individuals who are LTSS CP eligible.

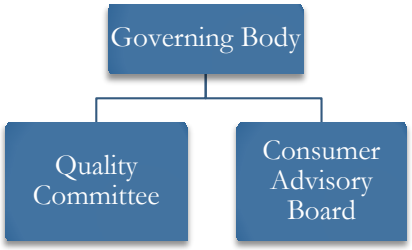
Target Population: The target population for this initiative includes individuals who are LTSS CP eligible and Engaged.

Measures for Success: Data related to this initiative will be continuously monitored through our Quality Committee. Measures of success will include:

- The number of integrated care plans that include MVCP's LTSS Care Plan as part of the overall ACO ICP.

3. Quality Management Committee

The MVCP will maintain a multidisciplinary committee structure that drives quality improvement through the review of quality data, includes representatives from each affiliated partner, and incorporates feedback from MVCP's Consumer Advisory Board. Our Quality Committee will meet monthly and be responsible for 1) identification of quality improvement opportunities; 2) finalizing intervention strategies to improve quality and cost-effectiveness; 3) establishing timeframes for interventions; and 4) tracking the effectiveness of interventions and making modifications to improvement strategies, as needed. The Quality Committee will report to the Governing Body as shown below.



Performance data will be reported to the Quality Committee which analyzes data against program goals and develops performance improvement initiatives. This committee will meet monthly and include one representative from each affiliated partner and will be chaired by the Program Director.

J. Coordination with ACOs and MCOs

1. Communicating MVCP's Skills and Expertise to ACOs and MCOs

We have already initiated discussions with ACOs who are members of our NCC and MCOs in our service area to discuss integration strategies. Such discussions will continue over the next several months as BH CP, LTSS CP, ACO and MCO contracts are awarded by EOHHS and, as Management Agreements are developed. We are communicating with and will continue to educate ACOs and MCOs regarding:

- The contribution that the MVCP can make to delivering quality care for individuals with LTSS needs. We will impact integration, patient satisfaction and Total Cost of Care (TCOC) among other measures, all of which will be vitally important to our Enrollees and to our organization, ACOS and MCOs our joint efforts to deliver care.
- The breadth and depth of LTSS CP services available to Enrollees who are eligible for such services. For example, we will discuss the specialized nature of the LTSS Care Plan and ongoing care plan implementation and monitoring.
- Collaborative strategies to integrate care for LTSS CP eligible individuals in the assessment, care planning, and care delivery process.
- Shared responsibility in caring for MassHealth Members with the greatest needs.
- The importance of primary care delivery for individuals with LTSS needs, many of whom go without primary care services for a variety of reasons.

2. Branding and Marketing with ACOs and MCOs

The MVCP's branding and marketing plans will be guided by MassHealth policy and procedure, which prohibits MassHealth vendors from directly marketing to Enrollees.

We believe that we are not marketing a product, but rather educating people about a valuable potential resource. It is important that effective branding materials are created, and outreach and education activities are well defined and comprehensive. To that end:

- Executive Leadership staff is proactive in network and outreach activities with community partners. We are quick to visit and establish our willingness to be an effective partner in care. We have a long practice off shaping ideas into reality. We also have a long history of working in partnership with multiple partners and disciplines to create an effective quality care program.
- The development staff at the agency includes both design and production capacity for marketing and education materials. We also have many media tools at our disposal to get our message out and our efforts "branded." That includes:
  - An e-newsletter distributed monthly to a wide range of readers

- An active website with a recent portal established specifically for caregivers
- A Facebook page for agency news that is managed daily
- Video production capacity
- A weekly newspaper column that covers the Merrimack Valley readership and includes a Spanish-language newspaper
- Guest appearances on radio and TV programs

ESMV's Development staff also create and produce resource and education materials for individual programs, and have vast experience working in teams and across disciplines to hone the right message and "look." They produce all agency annual reports, education materials, and resources, including a comprehensive resource guide for both aging and disability interests as well as a "person-centered" resource and planning guide for veterans.

3. Collaboration with ACOs and MCOs

The MVCP will provide information to all ACO and MCO partners in the Service Areas for which this bid applies. We intend to contract with all ACOs and MCOs in three Service Areas and will employ the collaboration strategy described above.

4. Conflict Resolution

The MVCP will partner closely with ACOs in the Service Areas to serve the needs of Enrollees with LTSS needs. Our LTSS CP will leverage and build upon the strengths that ESMV and NILP and our NCC, bring to this engagement. While we do not anticipate disagreements in areas of shared responsibility, we recognize that differences of opinion may arise, specifically related to care coordination decisions that affect Enrollees or, the way the Contract is managed. Our mutual intention is to resolve those disagreements in a timely manner that causes no harm whatsoever to Enrollees and, maintains compliance with the terms of the contract.

K. Providing Culturally Competent and Informed Services and Supports

1. Effective, Equitable, Understandable, and Respectful Quality Supports

ESMV has over 40 years of experience accommodating the diverse needs and special interests of consumers. These include:

1. Our Information and Referral department dedicated to resource development and maintenance of current information. Our bilingual capacity includes 16 languages spoken by staff in the agency and a formal contract with an interpreter service for languages not covered by staff.
2. ESMV prints educational materials in different languages including Spanish and Khmer. NILP has a full-time Deaf staff person and an ASL Interpreter on staff; they regularly utilize CDI, CART, Relay Services, Video Phone, Braille, Large Print, and accessible computers in our daily operations and special events. NILP also owns 20 Assistive Listening Devices that are readily accessible for any consumer or staff to use. NILP provides extensive peer role modeling and related services for dozens of people who are Deaf Hard of hearing, and late-deafened.
3. We use different platforms, including social media, ESMV website with portals for specific populations "e-newsletters", and web-based training platforms.

In addition to our Help Desk staff who assist callers by phone or TTY device, ESMV's website describes our capacity to offer language and communication assistance (described above). NILP's website also describes their linguistic and assistive capacity, which includes a full-time Deaf staff

person and an ASL Interpreter on staff. Both agencies respond to specific requests and special needs related to communication promptly, either through in-house resources or contracted services.

NILP's Deaf and Hard of Hearing Independent Living Services (DHILS) Program is highly visible within the deaf community. DHILS staff work with people who are culturally Deaf, late deafened or hard of hearing offering a comprehensive array of services to help consumers live independently.

The MVCP understands the critical role that culture, ethnicity, and ethnicity play in equal access to health care, and enrollees engage more easily when systems, services, and providers are culturally, linguistically and geographically sensitive. ESMV's and NILP's processes are designed with the Enrollee at the center of their care, regardless of language, age, race, ethnicity, preferences, beliefs, or disability.

We recognize that "culture" encompasses diverse language, racial or ethnic background, national origin, immigration/refugee experience, physical or mental disability, religious affiliation, gender and gender identity, and sexual orientation. During screening, we offer the Enrollee an opportunity to identify any preferences that impact how they view and access services. Their preferences will guide our care planning.

NILP's DHILS program also works collaboratively with their Recovery Learning Community (NERLC) to provide wellness and recovery supports and services to consumers who are Deaf or hard of hearing who also have a BH condition. Supports include monthly Deaf Peer groups and a Deaf Parent Support group to provide them with information and support.

In training, both ESMV and NILP will emphasize communication and cultural competence with diverse experiences, belief systems, and cultures. NILP's Training and Learning Collaborative (TLC) offers extensive training in Disability Awareness and Cultural Competence. TLC's core curriculum addresses: History, Philosophy & Consumer Direction; ADA and Cultural Competence – Beyond Compliance to the Real Spirit of the Law; Diverse Experiences and Cultures within the Disability Community; Cultural Competency in diverse cross-disability populations including Enrollee self-determination and autonomy in the Integrated Care Team.

2. Expertise and Experience Providing Care to Special Populations

Table Section 7.5.K.2. Expertise and Experience Providing Care to Special Populations

Special Population	ESMV	NILP
Homeless Individuals	ESMV meets Enrollees at any location where they are comfortable including, tent cities, homeless shelters, or congregate meal sites.	NILP also meets Enrollees at any location where they are comfortable (homeless shelters, or congregate meal sites).
LGBTQ Populations	ESMV co-sponsors an LGBT Senior Social Connection, offering participants the chance to connect, and build a sense of community	Recovery Learning Community hosts peer support groups monthly including LBGTQIA and Allies
Criminal Justice-involved Individuals	ESMV's Protective Services staff often work with individuals who have had criminal justice involvement. People who experience homelessness, struggle with substance abuse/addiction, and/or mental illness have often had such contact.	NILP 's Peer Recovery Program has partnered with youth and adults with involvement in the criminal justice system. A history of court involvement due to substance use and recovery wellness can be challenging. Peers with lived experience offer a special perspective in providing care to these individuals. NILP also collaborated with the Turning Point Re-Entry Program (TPRP), designed to help inmates from

Special Population	ESMV	NILP
		the Essex County Sheriff's Department re-enter society.
Low Vision, Deaf or Hard of Hearing	ESMV assists many consumers with low vision or hearing impairments. We connect consumers with resources from the Perkins School, MCB, ASL interpreter services and we have TTY access.	NERLC peer support groups monthly including Deaf or hard of hearing services led by a Deaf peer.
Individuals with Cognitive Disabilities	ESMV serves individuals with cognitive disabilities. We also have a federal grant to promote screening and identification of older adults with TBI and referral to SHIP, BIA, or to Habilitation Therapy, Adult Day Health programs or in-home LTSS, if appropriate.	NILP supports individuals with brain injuries and cognitive impairments in developing self-help skills, a recovery orientation, and self-advocacy skills.

Community Partner Program Budget Report

Family Service Association

	Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
	Estimated Enrollees- Start of Period (All Enrollees)		700	805	968	1,000	1,000	
	Estimated Enrollees - End of Period (All Enrollees)		805	968	1,000	1,000	1,000	
	Estimated Enrollees - Monthly Average		757	885	992	1,000	1,000	
	Total Estimated Program Revenue		**$ 423,920**	**$ 849,600**	**$ 952,320**	**$ 960,000**	**$ 960,000**	**$ 4,145,840**
	At- Risk Withhold Rate			0%	0%	0%	0%	
	Withhold funds			$ -	$ -	$ -	$ -	$ -
	Revenue for Operations		$ 423,920	$ 849,600	$ 952,320	$ 960,000	$ 960,000	$ 4,145,840
	Program Expenses	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
1	**Salary**	$ 144,634	$ 365,874	$ 716,419	$ 777,431	$ 799,379	$ 790,906	$ 3,594,643.34
2	**Fringe**	$ 43,390	$ 109,762	$ 214,926	$ 233,229	$ 239,814	$ 237,272	$ 1,078,392.79
	Total Personnel Costs	$ 188,024	$ 475,637	$ 931,345	$ 1,010,660	$ 1,039,193	$ 1,028,178	$ 4,673,036
3	**Training & Professional Development**	$ 400	$ 400	$ -	$ -	$ -	$ -	$ 800
4	**Travel**	$ 4,297	$ 40,706	$ 59,335	$ 51,610	$ 51,610	$ 46,810	$ 254,368
5	**Equipment**	$ -	$ 654	$ 2,420	$ 2,420	$ 2,420	$ 2,420	$ 10,334
6	**Supplies**	$ 2,662	$ 3,087	$ 5,892	$ 6,328	$ 7,092	$ 7,092	$ 32,152
7	**Contract Services** (consulting, professional)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	**Software licensing**	$ 497	$ 4,347	$ 7,452	$ 7,452	$ 7,452	$ 7,452	$ 34,652
9	**Telecommunications**	$ 2,355	$ 8,750	$ 15,636	$ 15,636	$ 15,636	$ 15,636	$ 73,649
10	**Occupancy** (rent, utilities, maintenance)	$ 5,955	$ 26,080	$ 44,701	$ 44,701	$ 44,701	$ 44,701	$ 210,840
11	**Other**	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Total Direct Costs	$ 204,189	$ 559,660	$ 1,066,781	$ 1,138,807	$ 1,168,104	$ 1,152,289	$ 5,289,831
12	**Indirect Cost/Administrative Overhead** **15.0%**	**$ 30,628**	**$ 83,949**	**$ 160,017**	**$ 170,821**	**$ 175,216**	**$ 172,843**	$ 793,475
	TOTAL EXPENSES	$ 234,817	$ 643,609	$ 1,226,798	$ 1,309,628	$ 1,343,320	$ 1,325,132	$ 6,083,305
	Surplus/Shortfall	*$ (234,817)*	*$ (219,689)*	*$ (377,198)*	*$ (357,308)*	*$ (383,320)*	*$ (365,132)*	*$ (1,937,465)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Director of Healthcare Transformation	$ 78,241.80	1.00	7	$ 45,641
Program Supervisor	$ 45,354.40	1.00	5	$ 18,898
LTSS Community Partner Care Coordinator	$ 38,220.00	7.00	2	$ 44,590
LTSS Community Partner Support Worker	$ 27,300.00	2.00	2	$ 9,100
LTSS Community Partner Support Worker	$ 29,120.00	1.00	2	$ 4,853
Administrative Assistant	$ 36,946.00	1	7	$ 21,552
				$ -
				$ -
				$ -
Total Salary (Program Budget Line 1)		**$12.00**		**$ 144,634**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 144,633.88	30%	$ 43,390
Total Fringe (Program Budget Line 2)			**$ 43,390**

Total Personnel*	**$ 188,024**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

Director Of Healthcare Transformation: Oversee all aspects of the services, including program development, operations, analytics, hiring, supervising, and training staff.

Program Supervisor: Provides direct supervision to LTSS Community Partner Care Coordinators and LTSS Community Partner Support Workers to ensure program processes, philosophy, and services are high quality

LTSS Community Partner Care Coordinator: Promotes coordination in the delivery and receipt of LTSS to enrollees assigned by Accountable Care Organizations (ACO) and Managed Care Organizations (MCO).

LTSS Community Partner Support Worker**:** Provides support to the LTSS Care Coordinator to promote coordination in the delivery and receipt of LTSS to enrollees assigned by Accountable Care Organizations (ACO) and Managed Care Organizations (MCO).

Administrative Assistant: Provide clerical and organizational support

Some expenses in this section were shifted to indirect per the budget guidance document instructions.

Fringe benefits includes health insurance for employees. Estimates are based current utilization of a variety of plans that run

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Cultural Competency			$ 400.00
Total Training and Professional Development (Program Budget Line 3)			**$ 400.00**

Provide a description of each Training and Professional Development line item included in the table above:

Cultural Competency: 1 – 4 hour training on Cultural Competency for all employees through Katie Brown Educational Program at a flat rate of $400.00 for 11 FTE's

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
Dir of Healthcare Transformation	698.6	7	0.535	$ 2,616.15
Program Supervisor	320.4	5	0.535	$ 857.07
LTSS Community Partner Care Coordinators	321	2	0.535	$ 343.47
			Total Mileage	$ 3,816.69

Travel Expense Description	Cost
Total Mileage	$ 3,816.69
Parking and tolls	$ 480.00
Total Travel (Program Budget Line 4)	**$ 4,296.69**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

Total Mileage

Program Director: Estimate includes regular trips to Boston and Worcester, in addition to miles for covering proposed geographic area for education and relationship building with ACO's/MCO's

Supervisor: Estimate includes regular trips to Boston and Worcester, in addition to miles for covering proposed geographic area for education and coordination and meetings with ACO's/MCO's.

Community Partners: Estimate includes regular trips to Boston and Worcester for educational purposes, in addition to miles for covering proposed geographic area for public education

Parking: Based on estimate of two trips per month to Boston/Worcester

Cost was added since original submission to ensure enrolles get assistance as needed.

Row 5 - Equipment

Description of Equipment	Unit Cost	#units or FTEs	Cost
			$ -
		Total Equipment (Program Budget Line 5)	**$ -**

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost

Printing supplies	53.85	4	$ 215.40
Cartridges	47.47	10	$ 474.70
Paper	30.99	10	$ 309.90
Desk supplies	100	12	$ 1,200.00
Postage			$ 461.60
Total Supplies (Program Budget Line 6)			**$ 2,661.60**

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:
Printing

Printing supplies, cartridges, and paper: Cost determined by current vendor

Postage: To send education materials, letters, flyers.

Desk Supplies: Costs include: desk organizer, trash basket, stapler, scissors, tape dispensers, calculator, writing pads, envelopes,

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
License for Director	289.8	1	$ 289.80
License for Supervisor	207	1	$ 207.00
Total Software Licensing (Program Budget Line 8)			**$ 496.80**

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Carelogic licenses: Costs included for access during preparatory budget period for monitoring and testing of the system.
for Director for 7 mths, for Supervisor for 5 mths @ $41.40 per mth

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Smart phone data plans			

Director of Healthcare Transformation	$	371.00	1	$	371.00
Program Supervisor	$	265.00	1	$	265.00
LTSS Community Partners Care Coordinators	$	159.00	7	$	1,113.00
LTSS Community Partner Support Workers	$	106.00	3	$	318.00
Hosted Email Accounts					
Director of Healthcare Transformation	$	63.00	1	$	63.00
Program Supervisor	$	45.00	1	$	45.00
LTSS Community Partners Care Coordinators	$	18.00	7	$	126.00
LTSS Community Partner Support Workers	$	18.00	3	$	54.00

				$	-
			Total Telecommunications (Program Budget Line 9)	**$**	**2,355.00**

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Smart phones with data plan: All employees will be issued smart phones upon hire to ensure they are accessible to clients and other providers, and to allow efficient and timely communication while in the community. *for Director for 7 mths, for Supervisor for 5 mths, for 7 LTSS Care Coordinators for 2 ,3 LTSS Community Partner Support Workers for 2 mth. The cost for each individual license is currently $53.00.*

Hosted e-mail accounts: Provide all employees with electronic communications, including encryption for confidential communications.

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Fall River Office	905	6.58	$ 5,954.90
			$ -
			$ -
		Total Occupancy (Program Budget Line 10)	**$ 5,954.90**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

Rent: Work location needed for employees who are developing program. Office space is calculated @ $11.36 per sq for 905 sq ft of space for the 7 mths - $850.70 * 7 mths

Rental costs have been adjusted to reflect the new format provided and the change in budget period

Row 11 - Other

Other Direct Expense Description	Cost

Total Other Direct Costs (Program Budget Line 11)	**$ -**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 12)		**$ -**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Indirect cost**:** rate of 15%

FSA Senior Leadership will provide direct oversight to program during implementation period, as well as administrative guidance to ensure program has full agency service support and seamless integration with other organization programs. This includes programatic, financial (payroll and accounting), technological and operational services and support, including professional laibility insurance. In addition, indirect costs include leasing or routine replacement (depreciation and financing interest only) of office equipment, costs related to occupancy of administrative premises, some officer/director compensation, auditing, management costs, working capital interest, and other similar or related resources /expenses.

Community Partner Infrastructure Budget Report

Family Service Association

	Infrastructure Investment Funding		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
	PMPM Infrastructure Rate			$ 75.00	$ 49.72	$ 43.28	$ 36.40	$ 29.34	
	Engaged Enrollees			805	805	968	1,000	1,000	
	Estimated Infrastructure Funds			$ 422,625	$ 480,295	$ 502,740	$ 436,800	$ 352,080	**$ 2,194,541**
	At- Risk Withhold Rate				5%	10%	15%	20%	
	Withhold				$ 24,015	$ 50,274	$ 65,520	$ 70,416	**$ 210,225**
	TOTAL MAXIMUM FUNDS AVAILABLE		$ 450,000	$ 422,625	$ 456,280	$ 452,466	$ 371,280	$ 281,664	**$ 2,434,316**
	Infrastructure Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
	Technology								
1	**IT Staffing including Fringe**		$ 28,574	$ -	$ -	$ -	$ -	$ -	**$ 28,574**
2	**Development Adaptation of EHR and/or Care Management System**		$ 46,200	$ 4,250	$ 3,000	$ -	$ -	$ -	**$ 53,450**
3	**Technology for Service Delivery**		$ 27,080	$ 6,090	$ -	$ -	$ -	$ -	**$ 33,170**
4	**Other Technology Expenses**		$ 7,571	$ 800	$ 800	$ 800	$ 800	$ 800	**$ 11,571**
	Total Technology		$ 109,425	$ 11,140	$ 3,800	$ 800	$ 800	$ 800	**$ 126,765**
	Workforce Development								
5	**Workforce Development staffing including Fringe**		$ 14,302	$ -	$ -	$ -	$ -	$ -	**$ 14,302**
6	**Recruitment Expenses**		$ 21,331	$ -	$ -	$ -	$ -	$ -	**$ 21,331**
7	**Training Expenses**		$ 13,725	$ 4,725	$ 2,535	$ 2,685	$ 2,585	$ 2,510	**$ 28,766**
8	**Retention Expenses**		$ 1,532	$ -	$ -	$ -	$ -	$ -	**$ 1,532**
	Total Workforce Development		$ 50,891	$ 4,725	$ 2,535	$ 2,685	$ 2,585	$ 2,510	**$ 65,931**
	Business Start Up Costs								
9	**Office Equipment (PBP & BP1 only)**		$ 800	$ -					**$ 800**
10	**Office Furniture (PBP & BP1 only)**		$ 11,349	$ -					**$ 11,349**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**		$ 234,817	$ 219,689	$ 377,198	$ 357,308			**$ 1,189,013**
	Total Business Start Up Costs		$ 246,966	$ 219,689	$ 377,198	$ 357,308	$ -	$ -	**$ 1,201,162**
	Operational Infrastructure								
12	**Operation Staffing including Fringe**		$ 10,142	$ -	$ -	$ -	$ -	$ -	**$ 10,142**
13	**Other Operational Expenses**		$ 4,401	$ 1,745	$ 1,785	$ 2,537	$ 2,385	$ 1,745	**$ 14,598**
	Total Operational Infrastructure		$ 14,543	$ 1,745	$ 1,785	$ 2,537	$ 2,385	$ 1,745	**$ 24,740**
14	**Indirect Cost/Administrative Overhead Rate**	15.0%	$ 28,051	$ 2,642	$ 1,218	$ 903	$ 866	$ 758	**$ 34,438**
	TOTAL INVESTMENTS		**$ 449,875**	**$ 239,941**	**$ 386,536**	**$ 364,234**	**$ 6,636**	**$ 5,813**	$ 1,453,035

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
IT Manager	$ 62,662.60	0.29	7	$ 10,600
IT Technical Assistant	$ 41,808.00	0.1	7	$ 2,439
SQL Report Writer	$ 38,316.00	0.4	7	$ 8,940
				$ -
	Total Salary	0.79		$ 21,980
	Fringe rate	30.0%	Total Fringe	$ 6,594
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 28,574**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

IT Manager: Responsible for the overall development and implementation of the EHR, including monitoring consultative service provision by Carelogic, developing training documentation, and technology deployment for sites. Provides oversight of IT employees to ensure equipment is operational and EHR workflows and reports are meeting programmatic needs. **The budget has been adjusted so that this position will assume project management responsibilities once the plan is established by the consultants, and also provide day-to-day oversight of all technology activities.**

IT Technical Assistant: Ensure all equipment is properly installed, configured, and operational. Provide proper security access to end-user.

SQL Report Writer: Create reports within the EHR to allow for efficient proper workflow for users, as well as provide analytics to program leadership to assist with monitoring operations and provide useful information for decision making. **This is a new position in the IT department since the original proposal, and will provide some report writing that had been previously incorporated into the consultant's hours.**

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Qualifacts-Carelogic Consultation	$46,200
Total Development and Adaptation of EHR and Care Management System (Infrastructure Budget Line 2)	$46,200

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Qualifact - Carelogic Consultation: Assistance and consultation will focus on developing configurable forms and user- friendly service documents, mapping for new services and workflow development, secure access to share data with ACO's/MCO's and integration of records. Services will also include comprehensive data analytics/reporting development for compliance, outcome and quality measures to meet operational, State, and payer needs and requirements.

This amount has been decreased from the original proposal and includes all contract services previously listed in Program Budget Year one. FSA has hired a SQL Report Writer. This position can perform some of the work that would have been delegated to the consultants.

Row 3 - Technology for Service Delivery

Description of Expense	Cost
Desktop Computers	$ 4,320.00
Surface Tablets	$ 18,360.00
Monitors and adaptors	$ 2,400.00
Chromebooks	$ 2,000.00
Total Technology for Service Delivery (Infrastructure Budget Line 3)	**$ 27,080.00**

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Desktop computers: 4 desktops @ $1080.00 each will be located in each office to allow for efficient work production, specifically creating documents not related to EHR.

Surface Tablets: 12 tablets @$ 1530.00 each will be issued to all program employees to allow for ease while working in the field, including access to the EHR. (18,360.00)

Desktop monitors and adapters: 12 monitors with adaptors @ $200.00 each will be used to allow for ease in using EHR and other software for office -based work (e.g. client document creation).($2400.00)

Chromebooks: 5 chromebooks @ $400.00 each will be used by clients, with assistance from program staff, to afford internet access for education, research, and assistance with securing appropriate services.

Since the initial proposal, FSA has completed some IT upgrades. The increase in Row 3 from the original proposal reflects the cost of new appliances and installation for LTSS CP Supports that did not exist at the time of the proposal.

Row 4 - Other Technology Expenses

Description of Expense	Cost
Network Switch and Wiring	$ 4,000.00
Website development	$ 379.10
Internet Security and VPN connectivity	$ 1,666.67
Budgeting and Accounting Software set -up fees	$ 1,000.00
Mileage software fees	$ 525.00
Total Other Technology Expenses (Infrastructure Budget Line 4)	**$ 7,570.77**

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Network Switch and Wiring: Ensure technology is accessible with computers, printers, fax and copier. Cost is based on similar recent work project.

Website development: FRFSA.org website will be enhanced to provide program description, contact information, and educational information, including useful links. **This was an addition from the previous proposal to ensure optimal visibility.**

Internet security and VPN connectivity: Secure internet connectivity and provide access via VPN to employees from remote location. *This increase includes the cost of the appliance (Sonic Wall) and installation.*

Budgeting and Accounting Software set-up fees: Set up fees to build new program into current system.

Mileage Software User fees-: Fees for employee mileage tracking and payment

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
HR Coordinator	$ 32,032.00	0.10	7	$ 1,869
Recruitment Manager	$ 26,000.00	1.00	4	$ 8,667
HR Generalist	$ 39,985.40	0.02	7	$ 466
	Total Salary	1.12		$ 11,002
	Fringe rate	30.0%	Total Fringe	$ 3,301
	Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)			**$ 14,302**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

HR Coordinator: Provide assistance with recruiting (advertising, screening, references) new employees and conducting part of new employee orientation

Recruitment Manager: Implement recruitment plan, and ensure timeliness of hiring and on-boarding processes. **This temporary position was added to ensure timely recruitment to meet proposed staffing patterns will be in place on June 1, 2018.**

HR Generalist: Provide some portions of new employee orientation, include benefit administration and data tracking

Other adjustments within the Workforce Development Staffing Row reflect changes to accommodate the adjusted start date for the contract.

Row 6 - Recruitment Expenses

Description of Expense	Cost
Employee Referral Bonuses	$ 1,000.00
Sign-on bonuses	$ 11,000.00
Advertisement	$ 9,331.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 21,331.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Employee referral bonuses : Bonuses ill be awarded to existing employees who refer candidates for these positions; Program Supervisor ,LTSS Community Partner Care Coordinator and LTSS Community Partner Support Worker

Referral Award Program Amount:

Referral awards will be made in two payments. The first award of a $100 Amazon Gift Card will be made after the referred candidate has been employed for a minimum of one week. The final award, a $150 Amazon Gift Card will be made after the new employee has completed his or her first six months of employment. Maximum estimated amount would be $1,000.00

Sign on bonuses : Bonuses will be offered to well-qualified candidates who accept a position in the program. Increased from previous budget due to local competition. A sign-on bonus will be offered to well-qualified candidates who accept a position in the following roles:

Program Supervisor - $1,000
LTSS Community Partner Care Coordinator - $7,000
LTSS Community Partner Support Worker - $3,000

Advertisement: A targeted recruitment plan will include multiple sources, including on-line sources (Indeed.com , O'Jornal , Craig's List, and Idealist.org). Additional advertising through local media will include SouthCoast Media, and Fall River Herald News.
A targeted recruitment plan will include the following on-line sources and local media sources:

Indeed.com @ $3,000.00 each month of the Infrastructure period of 2 months.	$ 6,000.00
Craig's List @ $40.00 per week every other week, for 5 month period.	$ 560.00
Idealist.org @ $90.00 per job posting for 30 days, for 5 month period.	$ 450.00
O'Jornal @ $180.00 per month for 5 month.	$ 900.00
Herald News @ $395.00 for 3 month period.	$1,185.00
Southcoast Media @ $236.00 to start multiple publications up to 5 weeks.	$ 236.00

This was increased to ensure better visibility in competitive market.

Row 7 - Training Expenses

Description of Expense	Cost
Trauma Informed Care	$ 3,000.00
Motivational Interviewing	$ 3,400.00
Engagement Strategies	$ 1,200.00
Case Management/Care Coordination Prog.	$ 5,000.00
Meetings with Community Partners	$ 1,125.40
Total Training Expenses (Infrastructure Budget Line 7)	**$ 13,725.40**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Trauma Informed Care: 3 - 5 hour training sessions for all employees on Trauma Informed Care, Mental Health First Aid and Working with adult survivors of trauma through The Center for Professional & Community Education at a flat rate of $3000.00 for 11 FTE's

Motivational Interviewing: 4 – 4 hour training sessions for all employees on Motivational Interviewing through The Center for Professional & Community Education at a flat rate of $3400.00 for 11 FTE's

Engagement Strategies: 3- 3 hour trainings on Engagement Strategies for all employees by H & H Consulting, LLC. at a flat rate of $1200.00 for 11 FTE's

Case Management/Care Coordination Program: 8 employees will participate in an 8 week Case Management/Care Coordination on-line course offered by University of Southern Indiana at a rate of $625.00 per staff for 8 FTE's

Conferences and Meetings: Food for monthly meetings for proivder network/advisory work groups in all satellite areas, including educational meetings

Row 8 - Retention Expenses

Description of Expense	Cost
Incentive payment	$ 1,532.42
Total Retention Expenses (Infrastructure Budget Line 8)	**$ 1,532.42**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Incentive payments: Provided to Program Director and IT Project Manager for completion of specific goals focused on timeliness of project completion and quality of service roll-out and provision. **This is a new retention strategy and expense that was not included in the original proposal.**

Community Partner Infrastructure Budget Report - Business Start Up Costs - Prep Budget Period

Row 9 - Office Equipment

Description of Expense	Cost
Desktop Printers	$ 800.00
Total Office Equipment (Infrastructure Budget Line 9)	**$ 800.00**

Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were determined:

Desktop Printers: 4 printers at $200.00 each provided at each site to allow employees to print written information to clients as appropriate.

Row 10 - Office Furniture

Description of Expense	Cost
Desks	$ 6,548.70
Chairs	$ 3,834.90
Filing cabinets	$ 598.00
Chair mats	$ 367.05
Total Office Furniture (Infrastructure Budget Line 10)	**$ 11,348.65**

Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:

Desks, chairs, filing cabinets, and chair mats: 15 desks at $436.58 each; 15 desk chairs and 15 guest chairs at $127.83 each; one four drawer file cabinet at $229.00 and one storage cabinet at $369.00; 15 chair mats at $24.47 each

Costs are based on costs from WB Mason.

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Data Coordinator	$ 38,183.60	0.21	7	$ 4,677.49
Director of Marketing	$ 71,066.09	0.08	7	$ 3,124
				$ -
	Total Salary	0.29		$ 7,801.21
	Fringe rate	30.0%	Total Fringe	$ 2,340.36
			Total Program Staffing including Fringe (Infrastructure Budget Line 12)	**$ 10,141.57**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Data Coordinator: Provide clerical support to Director of Healthcare Transformation, including data entry and reporting.

Director of Marketing**:** Develop and implement marketing plan which will include the creation of flyers, brochures and designs for additional marketing items

Row 13 - Other Operational Expenses

Description of Expense	Cost
Marketing	$ 1,701.23
Legal Fees	$ 2,700.00
Total Other Operational Expenses (Infrastructure Budget Line 13)	**$ 4,401.23**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Marketing: Includes business cards and all promotional materials, as well as sponsoring community meetings

Legal Fees: For review of contracts with ACO's and MCO's

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost	
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)			**$ -**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Indirect cost**:** rate of 15%

FSA Senior Leadership will provide direct oversight to program during implementation period, as well as administrative guidance to ensure program has full agency service support and seamless integration with other organization programs. This includes programatic, financial(Accounting and Payroll), and operational services and support, including professional liability insurance. In addition, indirect costs include leasing or routine replacement (depreciation and financing interest only) of office equipment, costs related to occupancy of administrative premises, some officer/director compensation, auditing, management costs, working capital interest, and other similar or related resources /expenses.

Community Partner Infrastructure Allocation Worksheet

	Family Service Association						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL FUNDS AVAILABLE	$ 450,000	$ 422,625	$ 456,280	$ 452,466	$ 371,280	$ 281,664	$ 2,434,316
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs							$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL INVESTMENTS	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Other Technology Investments	The delivery of LTSS CP Services will be supported by a fully electronic health record with the capacity for mobile use.	11/01/17	12/31/18	Purchase and configure all IT hardware	Hardware invoices						
Technology	Development and Adaptation of E.H.R/Care Management System	The LTSS CP Program EHR will support operations, evidence service delivery, with customized tracking and reporting specific to LTSS performance goals.	11/01/17	12/31/18	Establish contact with IT Consultant and finalize a comprehensive IT Work Plan for documentation workflow, data collection, reporting and analytics.	Agreement with IT Consultant; Draft IT Work Plan						
Workforce Development	Program Staffing including Fringe	The LTSS CP Program will be fully staffed, oriented, trained and prepared to meet obligations of the contract and target number of enrollees.	11/01/17	12/31/20	Hire Director of Healthcare Transformation and Program Supervisor	Signed job descriptions						
Workforce Development	Recruitment Expenses	Recruitment Plan will be driven by a written plan with strategies to recruit, hire and retain sufficient qualified Care Coordinators and Support Workers; including linguistic capacity, to meet the obligations of the contract and the needs of referred members.	11/01/17	12/31/20	Finalize and launch Recruitment Plan with strategies to recruit and hire Care Coordinators and Support Workers; including staff with sufficient linguistic capacity to meet needs of referred members.	Finalized Recruitment Plan, job postings, advertisements placed, interviews scheduled and completed						
Business Start Up Costs	Office Equipment	Fully equipped business locations for all service areas included in the LTSS CP contract	11/01/17	12/31/19	All required office equipment will be ordered/purchased and scheduled for delivery	Office equipment invoices						
Business Start Up Costs	Office Furniture	Fully furnished business locations for all service areas included in the LTSS CP contract	11/01/17	12/31/19	All required office furniture will be ordered/purchased and scheduled for delivery	Office furniture invoices						
Business Start Up Costs	Ramp-up Costs	Fully operational business locations for all service areas included in the LTSS CP contract	11/01/17	12/31/19	Draft Project Management plan to establish business locations across geographic region to be served	Project Management Plan						
Operational Infrastructure	Operation Staffing including Fringe	The LTSS CP will develop collaborative business relationships with other community providers, ACOs and MCOs	11/01/17	04/30/18	Finalize and execute ACO/MCO agreements	Executed agreements						
Operational Infrastructure	Other Operational Expenses	The LTSS CP program will operate with an established quality assurance and quality improvement framework to support the achievement of performance and quality measures.	11/01/17	12/31/19	Begin design of quality management infrastructure	Meeting minutes						

7.5 INITIAL DSRIP PARTICIPATION PLAN

A. Executive Summary: The five year Business Plan for implementing the LTSS CP program is detailed in the timeline and reflected through our response; but it can be articulated in a single simple vision statement. When awarded, FSA will dedicate all available resources to the complete and successful implementation of the LTSS CP program and all required quality measures. Over the last seven years, FSA has initiated four new and innovative programs. Each is delivering high quality services at or exceeding volume thresholds and each is sustainable. FSA has no reason to anticipate anything less than success with implementation of the LTSS CP Supports.

The implementation of the LTSS CP Supports will not be without its challenges. The first challenge we anticipate related to the delivery system is its capacity to meet the needs of engaged enrollees. For example, the waitlist for behavioral health care and medication management services is exceedingly long throughout the state. Meeting these needs will be a significant challenge. Proposed solutions will be to identify alternative supports and services that may sustain the individual until the required service is available. Care Coordinators (CC) can also work with the enrollees to keep their names current on waitlists, to check in periodically to determine their status on the waitlist and to ensure the enrollees are prepared to respond when offered an appointment. The CC can also advocate with the primary care providers to intervene to address behavioral health symptoms to the degree feasible. FSA will explore the feasibility of offering "on-demand" behavioral health services with open scheduling to address the demand in the Greater Fall River area.

Another challenge we anticipate related to the delivery system capacity relates to integration of care. The integration of physical, behavioral and substance use services, along with LTSS and other social services, is in its infancy as a delivery system. It will take a lot of education, system change, coordination and advocacy to ensure the successful reform from the current silo approach to full integration.

Yet another challenge is the lack of clear definition of an enrollee profile. There is a basic premise for defining who might be an optimal candidate for CP Supports, but since it has not yet occurred, there are no details known. Specifics around age, gender, diagnostic profile, family system, education, vocation and the like are vastly unknown. In addition, the public, those individuals we will attempt to serve, are totally disengaged from the topic. There is little community level knowledge of the passive enrollment that will occur with ACOs and no communication about CP Supports and what they intend to provide. This is not new to human services or new to FSA. We have successfully navigated such territory before and are confident we can succeed again. We have a strong reputation for serving all demographics. We are known in the geographic area we have applied to serve for having diverse programs. We know that we can leverage our existing community relationships and favorable reputation to succeed in the implementation of LTSS CP Supports and the community education that will need to accompany implementation.

Below is the projection for the ***minimum*** number of assigned and engaged enrollees we intend to support under the contract:

Calendar Year	Number Served	Please see LTSS Attachment A, Program Budget Report, for estimated enrollees
2018	No less than 805	
2019	No less than 968	
2020	No less than 1000	
2021	No less than 1000	
2022	No less than 1000	

FSA is bidding on the entire Southern Region of the state. FSA is already serving individuals in the majority of these cities and towns and by the operational start date, we will have the capacity to serve the entire area for which we are bidding. FSA already has satellite offices in locations that can support the

geographic regions we intend to serve. The current office space is sufficient in size to accommodate additional staff. As the program grows and reaches outputs needed, additional office space will be procured.

The plan for operationalizing the LTSS CP Supports is detailed in the timeline provided for section 7.5 F. It aligns with the budget formulation and the budget narrative. In short, FSA anticipates we will be fully operational for the entire geographic area for which we are bidding and ready to accept assignment of enrollees and begin outreach and engagement on June 1st, 2018.

B. Supporting Populations and Community Engagement

FSA has strong connections to the community and community members for the Service Area for which we are bidding. This includes existing collaborations with a variety of community-based organizations, advocacy groups, LTSS providers, housing and shelter providers and social service organizations. FSA was mindful in selecting the area for which we planned to bid; ensuring that it was well within the scope of current operations.

One of the most effective strategies for the successful implementation of LTSS CP Supports is building a strong network for collaboration and care coordination. FSA will capitalize upon the strong and meaningful connections with like-minded and mission driven providers and organizations we already have to further grow community connections in our Service Area. As the staffing plan details, care coordination teams will be strategically placed through the Service Area. This will embed workers in the various communities and make it possible for them to be active and involved, becoming the face of FSA and LTSS CP Supports in their assigned regions. Staff will join work groups, coalitions, advisory boards and the like and create provider networks where none exist.

A second strategy will be to share our knowledge and expertise. FSA has provided high quality services that are person-centered, mission driven and culturally responsive for 129 years. A lot of knowledge and expertise has been gained over that time and FSA will candidly share what we know, and the knowledge garnered over decades of service to advance LTSS CP Supports and better meet the needs of enrollees. Maintaining integrity and accountability will further support the development of strong community relationships. FSA has an outstanding reputation for open, honest and ethical operations. Those standards will not be compromised. Staff will be candid on what they can do and deliver on promises. Staff will honor commitments, fulfill requests and responsibilities and meet required deadlines in keeping with expectations for professional conduct.

Finally, FSA will maximize the use of technology and networking strategies to further advance the LTSS CP Supports. Staff will stay connected with community partners through email, social media, telephone and text messaging, FSA will take full advantage of mobile communication in support of promoting connections and maximizing availability.

Developing and sustaining community connections will also help to ensure staff stay informed of the ever-changing landscape of human services. One way to stay connected with up-to-date information on resources and providers is through the community connections coalitions. Another is through the Family Resource Centers throughout the state that are charged with coordinating resources for families. Most human service agencies have resource guides and FSA will continually update our accumulation of resources to be sure we have current information. FSA will also monitor email communications, participate in events sponsored by state agencies and ACOs/MCOs and maintain membership in trade organizations as a means of staying abreast of changes.

The scope of FSA's community contacts and collaborations is extensive. The table that follows provides a meaningful glimpse into the diverse connections FSA has developed in each of the regions we plan to serve.

GREATER FALL RIVER AREA			
Citizen's for Citizens	SSTAR	Steppingstone, Inc.	Fall River Housing Authority
Community Preservation Coalition	Fall River School Community Partnership	High Point Treatment and Recovery	Partners for a Healthy Community
Fall River Juvenile Court	Southeast Interagency Team	Bristol Elder Services	Community Health Network
Institute for Health and Recovery	DCF Trauma-informed Leadership Team	South Coast Anti-trafficking Group	Steward Health Care Network
Salvation Army	United Neighbors	Health First	United Way of GFR
Shepherd's Center	Child Protection Council	St. Vincent's Home	People, Inc.

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Cape Cod and the Islands			
Barnstable County Social Services	Department of Social Services of Hyannis	Family and Social Services in Hyannis	Eliot Community Human Services
Cape Cod Health Care	Justice Resource Institute	Catholic Social Services	May Institute
Child and Family Services of Cape Cod	Bay State Community Services	South Bay Community Services	SouthCoast Health System
Cape Cod Pride	Seven Hills	Community Systems, Inc.	VinFin
NAMI of Cape Cod	Falmouth Social Services	Kennedy Donovan Center	Family Continuity
Fellowship Health Resources	Martha's Vineyard Community Services	Cape Cod Resource Center	Cape Abilities
GREATER NEW BEDFORD			
Coastline Elder Services	Child and Family Services	The Bridge	Life Stream
Women's Resource Center	Seven Hills	PACE	Gateway Adult Day Health
Department of Human Services	Community Autism Resource	SouthCoast Wellness Collaborative	South Coastal Counties Legal Services
May Behavioral Health	Community Systems, Inc.	Better Community Living	United Interfaith Action
New Bedford Housing Authority	Department of Developmental Services	Community Connections Coalition	Fellowship Health Resources
Kennedy Donavan Center	Capeway Adult Day Heath	Mass Mentor	Catholic Social Services
GREATER TAUNTON			
A New Day	Sturdy Memorial Hosp.	Self Help, Inc.	Pride Inc. Day Habilitation
American Red Cross	ARC of Bristol County	DEAF, Inc.	Greater Taunton YMCA
Associates for Human Services	Department of Developmental Services	Department of Early Education and Care	Greenlock Therapeutic Riding Center
Brockton Area Multi Service Center	Social Security Administration	Options for Independent Living	Home for our Troops Taunton
Community Counseling of Bristol County	Taunton Dept. of Human Services	Brigham and Women's/Mass General Health Care Center	Commission for the Deaf & Hard of Hearing
Amego, Inc.	Father Bills and Mainspring	Dare Family Services	Southbay Mental Health
GREATER ATTLEBORO			
Comprehensive Social Services of Attleboro	Human Services of Southeastern Ma	ARC of Northern Bristol County	Big Brothers – Big Sisters
Hillside Adult Day Health	Doorways, Inc.	Community Care Services	Attleboro Housing Authority
New Hope, Inc.	Mansfield Day Habilitation	Our Daily Bread	Enable, Inc.
Self Help, Inc.	Community Health Link	Mansfield Food pantry	Attleboro Council On Aging
Beta Community Partnerships ,Inc.	Old Colony Habitat For Humanity	United Way of Greater Attleboro	Healthcare Transportation Resources
Harmony Adult Day Center	American Red Cross	Key Program	American Red Cross
GREATER BROCKTON			
BAMSI, Inc.	Blue Hills Family Center	Bayview Associates	MASSCAP
Brockton Coalition for Human Services	Jewish Family and Children's Services	South Shore Women's Resource Center	Northeast Health Services and family Counseling
Old Colony Elder Services	Lutheran Social Services	Mainspring Coalition	Interfaith Social Services
Brockton Area ARC	Salvation Army	Brockton Housing Authority	Brockton Neighbors United
Cope	Social Service League	Brockton Resource Center	Growthways, Inc.
Brockton Early Intervention	South Shore AIDSProject	Mass. Rehab. Commission	Brockton Social Services

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7.5 Community Partner Supports and Activities

Outreach: A diverse approach will be used to locate and engage enrollees with complex LTSS needs. One strategy will be to rely upon our relationships with other community providers who serve the target population to facilitate contact. FSA will also use our existing strong and well-established relationships as a foundation to further our network and expand to neighboring communities. While the CP Supports will be a new service, assigned enrollees are likely to have relationships with various community organizations and providers. That too can serve as a springboard to additional alliances, as FSA builds a bridge to connect with assigned and engaged enrollees through community collaborations.

It is the practice in FSA programs to work with members to identify areas of strength as well as areas of need. We then work with members to connect with resources in the community that may meet their needs. In this manner, we build community tenure and connections. In some instances, members have been in our programs for over 20 years, continuing to live in the communities where they were born and raised. We have a strong commitment to meet members where they are, work collaboratively to leverage individual strengths in order to mitigate and support areas of need. We work with members to create a realistic plan to get to where they want to be and then set the steps to support realization of their goals. These goals can be as small as preparing to accept services to preparing a nutritious meal, seeking social opportunities and rebuilding family connections. We have worked with members to take their first plane ride, establish their own savings account, use a debit card, seek and obtain employment and acquire their first pet. We have also worked with members to avoid eviction, resolve legal challenges and settle significant debts. FSA is well known in the community for being an organization that gets the job done. We are recognized for succeeding in serving individuals who have failed with other providers. We do what it takes to get the job done and that strong drive and commitment to person-centered and goal-directed service will be applied to the LTSS CP Supports.

Outreach is a common practice in current FSA programs. All employees are expected to be visible in the community and actively participate in community groups. Employees receive training to provide community education. Outreach has always been a part of job descriptions and our program leaders track the outreach of employees to help build their programs.

FSA already serves individuals with complex LTSS and BH needs and we will apply the specific approaches that have brought success in existing programs to locate and engage LTSS CP Support enrollees. First attempts at locating enrollees will be through the use of provided demographics; with telephone calls, written correspondence and drop-by visits forming the basis of initial attempts. Contacts with family, friends and authorized representatives will follow if the direct efforts prove unsuccessful. If an individual cannot be located, versus failing to respond, FSA will scan the network of inpatient facilities to rule out hospitalization. Community locations where the individual is likely to visit will also be checked. These can include community centers, shelters, food pantries, soup kitchens and community programs. FSA will also work with housing authorities to address housing instability. Basically, FSA will apply the full scope of existing resources and capacities and proven successful outreach strategies to locate and engage enrollees.

Successful engagement of the enrollee will hinge upon our effectiveness to connect on a genuine level with each individual and establish a meaningful relationship. The specific path may vary for each individual, but the basic approach will be consistent. FSA needs to identify that which is meaningful for the individual, where gaps exist and the wants and needs of enrollees. Working from a respectful perspective and allowing the individual to drive the process to the greatest extent feasible will lend credibility to FSA as a provider and foster more favorable outcomes. Trust will develop over time, but demonstrating respect, tolerance, understanding, openness and flexibility will lay a solid foundation for an effective partnership that fosters engagement.

Clear and honest communication will also be critical. From a general outreach and engagement perspective, materials need to be provided in a manner that is accessible to the target population, whether that be in the appropriate language, an accessible literacy style or in locations and venues that are likely to reach the target population. From a direct engagement perspective, successful interaction with assigned enrollees will require accessibility by staff and a consistent approach. Staff persons need to build trust by doing what they commit to do in a timely fashion. They also need to be available, responding to calls and messages in a timely manner. The presentation of the program and a demonstration of its anticipated achievements need to be clear, honest and upfront, particularly regarding the reasons the enrollee is assigned and how CP Supports can help.

Additional strategies include maintaining consistency by avoiding changes in workers. Engagement can be fostered by giving careful consideration to case assignment; matching enrollees with workers based on gender, age and cultural factors to the greatest extent feasible. Striking a balance between authority and enrollee empowerment will be important to achieving progress. Giving practical assistance will lend credence to the worker and to what they are trying to achieve. Ensuring the enrollees' voice is heard is also important. Taking a strength-based approach and celebrating small steps, emphasizing positive accomplishment, will put CP Supports in a favorable light rather than be perceived as a burdensome role. Being flexible and working at a pace that makes the assigned enrollee comfortable will also help to foster engagement. The FSA staff works every day with individuals who find themselves assigned or referred due to life circumstances or legal constraints and not solely by choice. FSA has effectively served these individuals and the majority ends their affiliation with FSA happy, whole and grateful for the encounter.

LTSS Care Planning: Care planning for a variety of services is an area of strength in every FSA program. Ensuring the enrollee has meaningful participation in the development and management of the LTSS Care Plan will be achieved using a variety of methods. The process begins with ensuring the assessment is in hand, that it is complete and that there have been no changes. That is followed by actions to ensure that the enrollee has a clear understanding of the CP Support role and intended impact or goals of participation. Offering the enrollee the option of an alternative CP Support not only meets contract requirements but demonstrates respect for individual choice as well as flexibility on the part of our organization.

Once it is established that the enrollee will engage, active participation in the planning process begins. The CP Support worker will assist the enrollee to identify and articulate realistic goals. The process will move at a pace that is comfortable for the enrollee and will include natural supports and other providers to the degree desired and approved by the enrollee. Workers will use motivational interviewing to help the enrollee articulate the path that should be pursued by the plan. The approach will take a strength-based rather than a problem-oriented approach. The enrollee will be offered choice in the planning process. Those choices will be provided in writing, using materials from various community providers as well as FSA summary materials. The CP Care Coordinator will work with the enrollee to weigh the pros and cons of each decision/option so that enrollees can make the best decision for their particular situation. When choosing service delivery providers, FSA will utilize technology to aid the enrollee in the decision making process. For example, we will use the internet to show the enrollee websites and photographs of locations, reviews if available and other relevant material to support choice. FSA will also be mindful of cultural factors and how they may influence decision-making and choice. The enrollee's choice will be evidenced in writing so that it is clear that the final decision, considering all available options, was made by the enrollee.

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FSA's Community Service Agency (CSA) has operated with a strength-based approach that, since its inception, has honored client/family voice and choice. In the most recent program evaluation, the program scored between 95% and 100% for creative brainstorming, individualized process, consumer voice and consumer choice. It exceeded the state mean score by 1 to 2% on each of the domains and the national mean by as much as 11%. FSA intends to model the CP Supports after this successful delivery of services, using Care Coordinators from the CSA to coach and model for the LTSS CPs as needed.

Care Team Participation: FSA's current LTSS programs demonstrate the same level of proficiency in coordinating care and exchanging essential documentation as its Children's Behavioral Health Initiative (CBHI) programs. This demonstrated capacity will be replicated for CP Supports, using many of the same workflow systems that have ensured success for existing services. In the current menu of LTSS programs, each service is required to share essential documents with primary care providers and fiscal agents. This may include assessments, service authorization requests and care plans. The workflow already exists to ensure this happens consistently. Programs have systems in place to facilitate timely and efficient communication for other providers and the process for CP Supports will be built upon this successful model. FSA will also enlist feedback from involved stakeholders to promote integration of LTSS communication. Stakeholders will be involved in establishing the most effective way to communicate and to achieve the mutually favorable outcomes for enrollees. Secure digital communication will be used to the greatest extent possible to make communication quick and efficient. The assignment of enrollees to Care Coordinators will be synchronized to match external stakeholders, when feasible, to promote efficiency. This will allow one or two coordinators to work with certain designees rather than require all CP Supports staff to contact the same providers for different enrollees.

A system of checks and balances exists within FSA to ensure compliance with external communication with stakeholders. The various reporting and data-sharing requirements are consistently met. One component of the system is FSA's internal record review committee. The committee assess compliance with key activities as well as the quality and appropriateness of care. The committee is comprised of peer reviewers from programs other than the one being evaluated. Committee members meet monthly and by the end of each calendar year, 100% of records for FSA program serving 125 individuals or less are reviewed. For larger programs, 50% are reviewed with 100% completed every two years. The case record review committee will be expanded to include the CP Supports as a means to ensure that the organization's high level of efficiency continues.

LTSS Care Coordination: The integration of LTSS CP Supports into the care team will be deliberate, with the right information shared with the right providers at the right time. The enrollee will be the center of the dialogue, with his/her needs and preferences ascertained, documented, and communicated to guide the delivery of care by all providers. Communication will be organized and deliberate with a primary goal of ensuring that the enrollee's needs are met.

Broad-based approaches to integrating the plan of care will include fostering teamwork between providers, using open, honest and direct communication and modelling collaboration. The application of care management principles will support the process, with care coordinators managing information, sharing the enrollee's perspective and promoting multi-disciplinary communication and cooperation. Care Coordinators will advocate, communicate, educate, identify and share appropriate, thereby facilitating access to care. Cultural beliefs, values and needs will be honored while helping the enrollee navigate the various care settings. Coordinators will take a holistic approach, advocating for the enrollee's family and support systems as well. The physical, emotional, financial, psychosocial, behavioral, housing, education and vocations needs will be integrated into the plan. The primary responsibility of CP Supports will be the

enrollee, and the coordination of care that is safe, timely, effective, equitable and client-centered; understanding that succeeding in these hallmarks ensures success for every provider. Care Coordinators will be adaptive, flexible and collaborative with a single focus on bringing the team of formal and informal supports together for the common goal of improving and/or maintaining the enrollee's clinical, functional, emotional and psychosocial state. The individual with complex LTSS and BH needs is at the focus of care. However, all providers will benefit when the individual achieves and maintains optimum wellness, self-care management and functional capacity. Care Coordinators will maintain privacy, confidentiality, enrollee health and safety through advocacy and strict adherence to ethical and legal standards, FSA policy and guidelines, and the mandates of the LTSS CP contract. The FSA Care Coordinators will use their education, skills, knowledge, competencies and experience to provide the highest quality supports to individuals with complex LTSS and BH needs.

Specific care coordination activities will also be employed. Assessment and monitoring will be ongoing expectations for contact with enrollees to identify and mitigate significant events such as life cycle stages, changes in relationships and exacerbation of health conditions. This can be achieved in part by integrating proactive components into the plan of care. It is important to continually monitor for change, identify triggers, clearly define baselines, and monitor follow-up with identified tasks and activities. The care plan should drive the process with the Care Coordinator working from the plan, measuring progress toward goals and adjusting and accommodating as service delivery unfolds. Establishing accountability and agreeing on individual responsibilities will eliminate confusion and duplication. It is essential to constantly work at communication with team members and provide rapid response to changes in the enrollee's status. Respecting the enrollee's choice, celebrating achievements, promoting linkage to community resources and acknowledging self-management gains will help build the confidence necessary for enrollees to mitigate life cycle events and changes.

Life cycle events and challenges can be either anticipated or unpredictable. Navigating unpredictable events successfully will require a strong foundation of trust with the enrollee. Spotlighting success and achievements can also mitigate the impact of unpredictable events. Demonstrating progress and positive achievement can soften the impact of a setback. As enrollees build self-management skills and an informal support network, life cycle events become challenges but not barriers to success.

Navigating predictable life cycle events, especially those that impact eligibility, requires foresight and planning. Helping the enrollee identify the upcoming event and how it may affect their goals is important; reflecting back to goal formulation, enrollee education and coaching, and honoring voice and choice. Managing life cycle events and fostering ongoing enrollee engagement can be achieved by promoting self-determination. Supporting a sense of control over one's own life, especially in times of crisis or when faced with events outside of one's control, is critical. Self-determination is a construct with many facets and there is no single practice or approach that will work for all enrollees in all situations. Hallmark principles include ensuring enrollees have access to the information they need, in a way that they can understand and use it. This will help them to make their own decisions and execute their own free will. All individuals have the capacity for self-determination, although fostering it requires an individualized approach. Skill building for problem-solving, decision-making, goal setting and self-advocacy may be needed. Modifying the service delivery environment to be more welcoming and supportive of self-determination may also be needed. Self-determination encourages the enrollee to be "the expert" on what is in their best interest, allowing them to control the services provided instead of the services controlling them. Strategies to promote ongoing engagement with care planning and implementation will include presenting all available options, while coaching the enrollee to recognize and weigh each option based on the risks and benefits of each choice. Aiding the enrollee to recognize potential long and short-term

implications of choices and proactively developing plans to overcome barriers will also build self-determination skills. Breaking down problem-solving into smaller steps will also foster engagement.

Strategies to promote self-determination will be paired with motivational interviewing to support ongoing engagement in care planning and implementation of the care plan. Care Coordinators will work to build a democratic partnership with enrollees. The role of the Care Coordinator, using motivational interviewing, is to build a collaborative partnership with enrollees. The Care Coordinator will be empathetic and supportive but also direct the enrollee toward self-motivated goal setting. As stated by Miller and Rollnick in *Motivational Interviewing: Preparing People for Change;* motivational interviewing is "more persuasive than coercive, more supportive than argumentative." The successful application of motivational interviewing techniques will express empathy through reflective listening. It will help enrollees see the difference and gaps between what they want, their goals, and their current patterns of behavior and decision-making. Care Coordinators will use a "parking lot" for sensitive or difficult topics that the enrollee may not be ready to address. This allows Care Coordinators and enrollees to acknowledge the topic, but understand that the enrollee is not ready to tackle that area. Care Coordinators will continue to address readiness and "parked" topics will be revisited as the enrollee builds trust with the Care Coordinator> This will help the enrollee to develop self-management skills and achieve successes to gain the confidence to tackle more complex challenges. Care Coordinators will demonstrate confidence in the enrollee and optimism; demonstrating respect by accepting and validating enrollees' feelings in a non-judgmental manner.

Transitions in Care: FSA will manage transitions in care successfully by motivating providers across various care settings to work as a team to make transitions smoother. The process begins with building strong, professional and respectful relationships with providers and keeping the client at the center of decision-making. The first step for promoting transitions is an accurate and appropriate care plan that is clearly communicated to all members of the enrollees' care team. As the enrollee transitions from one level of care to another and from one provider to another, the care plan should drive the process, following and supporting the goals identified by the enrollee. Facilitating this care plan and continually advocating for the enrollee's voice and choice will be a key responsibility for CP Support staff.

Another key responsibility for CP Support staff will be ensuring that the enrollee has the information needed to make informed choices about LTSS programs and providers as part of transitions. FSA will provide access to information about the providers and services available to the enrollee. The information will be presented in a manner that meets the enrollee's language and cognitive capacity. Some of the interventions that could be used include site visits, internet research with the enrollee, written brochures and materials, telephone contacts with provider staff and anonymous contact with current service recipients. Family members and personal representatives of the enrollee can be solicited to help gather information for the enrollee to help them make their best decisions. When multiple options are available, a comprehensive list will be provided for the enrollee. When only one option is available, that will be clearly explained. All work toward transitions will be clearly documented, as well as evidence of choice, in the enrollee record. FSA will present at least two choices, more if feasible; any time the enrollee is connected with services.

After a transition in care, assuming the enrollee remains engaged, the Care Coordinator will follow-up at prescribed intervals to support the transition and ensure the enrollee remains satisfied with the choice of provider. If there is indication of dissatisfaction, the Care Coordinator will work with the enrollee and provider to broker a solution. The identification of a designated contact person at the new provider who can serve as the point of contact for the enrollee and the Care Coordinator will further support transitions. Care Coordinators may provide the supports directly to the enrollee or facilitate supports from family and friends

and other natural supports to serve as transition "coaches". Coaches will ensure the enrollee is maintaining ground in self-care activities, know and recognize signs of distress related to the transition, and reflect optimism and compliment the enrollee's achievements during transition. Enrollees can also be coached to articulate their concerns, identify needed contacts and ways to address concerns. These actions empower the enrollee and provide a sense of control in a changing environment that can be unsettling and even frightening. Finally, the coaches can ensure that all follow-up activities related to the transition are completed within designated timelines.

Health and Wellness Coaching: Health and wellness education and coaching have been organizational priorities at FSA for the last decade. In 2007, in response to the Department of Public Health's Working on Wellness initiative, FSA embarked on a path to promote health and wellness for employees. The organization recognized that healthier employees would be better equipped to deliver quality services. We also believed that health and wellness education provided to employees would positively impact service recipients. FSA's success was well recognized with several awards and citations from state-wide and national publications on employee health.

The skills and knowledge acquired through the employee wellness program are readily transferrable to service recipients. Employees gained tremendous insight into the unique needs of adult learners. FSA staff were trained to deliver the Center for Disease Control (CDC) evidenced-based curriculum for Diabetes Prevention. Modules from that curriculum can be used for health and wellness coaching for enrollees. FSA offered a diverse array of tobacco cessation programs and interventions which can easily be replicated for enrollees. Weight management and improved nutrition have been recurrent themes in the employee wellness program, as well as management of hypertension, cholesterol and heart disease. The importance of physical exercise has been addressed with walking programs, activity challenges, exercise instruction and physical activity incentives. Once again, the curriculum and materials for these activities can be applied to support health and wellness coaching for enrollees.

The current LTSS programs within FSA employ nurses who can be consulted to support health and wellness coaching. FSA is prepared to offer individualized and even group coaching. Over the ten-year period of the employee wellness program, FSA has built strong alliances with health promoting organizations such as Partners for a Healthier Community, the YMCA, the Diabetes Association, the local chapters of the American Heart Association, American Lung Association and the American Cancer Society.

Beyond the realm of employee health achievements, FSA also has accomplishments in promoting community and public health. We have provided community-based and consumer health promotion for years. At the present time, FSA is wrapping up a program called *Eat to Live*. This nutrition education and coaching program strives to improve the eating habits of older adults and chronically disabled individuals. It features assessment, identification of needs, referral and linkage to community supports along with education, monthly coaching and hands-on assistance with meal preparation. To assess nutrition, the Mini-Nutritional Assessment (MNA) is administered. The MNA is a validated screening and assessment tool designed to identify individuals who are malnourished or at-risk of malnutrition. The MNA was developed over 20 years ago and is the most validated screening tool for use with adults. Once assessed, the program helps individuals recognize indicators of poor nutrition, access public assistance resources and learn simple ways the nutritional quality of food can be increased. The program helps adults make smart food choices and make the most of their limited financial resources.

FSA has also offered education on how to self-manage chronic conditions and the effects that illness has on people's lives. Education has been provided on chronic disease, the effective management of health, making lifestyle changes to support improved quality of life. Participants learn how to become

actively engaged consumers of healthcare rather than powerless victims of illness. Community-based health education has tackled medication management, weight control, physical activity, nutrition and effective communication with healthcare providers.

FSA provides fall prevention screening and education in all of its existing LTSS programs. Sparked by a rise in the number of individuals who experienced a fall event each year, FSA worked with the UMass Dartmouth Nursing Program to design and deploy a unique fall prevention program that included consumer education, employee education, screening and protective measures. The program produced remarkable results. According to CDC data at the time, 30% of elderly and disabled adults would experience at least one fall event in a year. For FSA consumers, that fall rate was at 21%, but was climbing from year to year. After the deployment of the fall prevention program, that number dropped to 9%. FSA continues to have fall rates among the population we serve in the 9 to11% range. The fall prevention initiative is a fundamental component of our LTSS programs and has been offered as a community education program through a variety of forums. Our fall prevention programs have been so successful that area social service agencies have asked FSA to continue to offer them as a part of other community service programs. Health and wellness education and coaching have been provided to FSA enrolled members in the LTSS programs and to the public as a form of community outreach. Additionally, the FSA Adult Day Health programs provided monthly wellness education to enrolled members.

FSA will work with enrollees to actively engage with primary care providers. We will encourage and support enrollees to effectively communicate with their providers to manage their health. At the same time, enrollees will be urged to comply with medication and therapeutic interventions and FSA will help them identify and overcome obstacles to compliance. FSA will coach to proactively manage their care and take advantage of preventative programs as a means of reducing costly emergency department visits in the future. In FY 16, our adult foster care program set a Performance Improvement Target to address the rising rate of emergency department (ED) usage. After any ED visit, nurses meet with members to look at what precipitated the visit and provide prevention education, including early warning signs of urinary tract infections, self-management of upper respiratory infections without fever, when to call the doctor and alternatives to ED visits such as urgent care centers. Thus far, the program has seen a 31% reduction in ED visits as of April 30th compared to last year at this time. Based on our proven success in providing evidence-based wellness programs, using validated screening instruments and the delivery of wellness education with measurable results, there is little doubt that FSA has the capacity and proven effectiveness to provide health and wellness coaching as stipulated in the Model Contract.

Connecting Enrollees to Social Services and Community Resources: Evaluating enrollees for social service needs and facilitating access to Flexible Supports will be achieved through a comprehensive assessment. FSA already has comprehensive assessment tools in place in its own LTSS programs. A combination of an FSA developed social service assessment and the MDS-Home Care is used in three of the four programs. FSA will create a Social Service Needs Assessment for CP Supports based on the tools already in use. Its development will be guided by principles established by the National Association of Social Work. The LTSS CP Supports assessment will include the following:

- Interpersonal Assessment – who are the important people in the enrollee's life; who can be relied upon and in what capacity, what formal and informal supports are they providing, what are they willing to continue to provide, and where do they need or want relief?

- Environmental Systems – what is significant in the enrollee's daily routine, what is lacking, what resources are available, what barriers or obstacles exist, is the environmental system safe, are there features of the environmental system that bring the enrollee joy/comfort?
- Social Context – what societal issues impact the enrollee positively and negatively, are there cultural, socioeconomic, race/ethnicity or socialization challenges, is the enrollee satisfied with the current level of socialization and community inclusion, are there advocacy issues that need to be addressed?
- Special Considerations – what makes the enrollee unique, are there language or literacy factors to be considered, are there unique communication needs, do grief, loss or trauma concerns exist that need to be addressed, is housing stable?
- Spirituality – what are the enrollee's beliefs and values and how will that influence care planning and service delivery?
- Transitions – are there predictable or foreseeable transitions to consider, any impending life cycle events that may impact the enrollee?

Upon completion of the assessment, areas for consideration will be identified with the enrollee and prioritized, based on the enrollee's choice. The Care Coordinator will work with enrollee to set goals based on the assessment findings and evidence those goals on the care plan. FSA will encourage self-directed care and facilitate access to services to the degree appropriate for and approved by each individual. FSA will work with the ACO to design cost effective service options that align with the enrollee's choice and that reduce or eliminate fragmentation and duplication. The care plan will guide Care Coordinator contacts and the delivery of services, keeping the findings of the Social Service Needs Assessment in the forefront of care. As stated earlier, the care plan will be widely communicated and the Care Coordinator will serve as an advocate for the enrollee and the established plan of care. The Social Service Needs Assessment will be updated annually and whenever there are significant changes in the enrollee's physical, mental or functional capacity as a means to ensure ongoing connections to community resources.

The scope of services for the LTSS Community Partners is broad and comprehensive. FSA has the expertise working with the identified population. Outreach, care planning, care team participation, care coordination, transitional care, health and wellness coaching and fostering connections to social services are hallmarks of human services. They are part of service delivery every day in FSA programs. FSA has excelled at the delivery of high quality human services for 129 years and we are confident we have the capacity to excel as the LTSS Community Partner for Southeastern Massachusetts and Cape Cod.

7.5 D. Innovative Technologies for Service Delivery Initially, FSA intends to deploy laptops, smart phones with roaming data capacity, tablets and netbooks in support of the delivery of LTSS CP supports. A variety of software systems, web-sites and applications will be used to make services efficient and effective. Tools like Skype and Face Time can help connect workers in different parts of the service area. They can also be used to engage enrollees if they have the tools to participate. FSA will utilize the capacity of mobile phones for communication including voice calls, texting and email to support mobile communications. Software applications for smartphones and tablets will also be used to serve as translation tools, adaptive technologies and other means to foster communication and enhance service delivery. FSA does not intend at this time to utilize any specific Case Management software systems as the current EHR is fully customizable to meet these needs. Signature pads will be deployed with laptops to gather enrollee signatures on required electronic documents. FSA will also make use of its website, Facebook and Twitter for outreach and to engage consumers. FSA staff will also make liberal use of internet research to find resources for consumers and share information.

While innovative technologies open a whole new realm of opportunities for workers and consumers, they can be fragile and create vulnerabilities. FSA will ensure that IT policies stay abreast of current trends and continually address the risk of service delivery in a digital world. Employee training will be critical to be sure privacy and confidentiality are maintained. Attention will also be paid to ensuring professional boundaries are maintained. FSA will also ensure that the ease of mobile and digital communication is used to support and enhance relationship development, and that the convenience does not hinder or replace face-to-face encounters.

Beyond what is known for innovative technologies, FSA proposes to take a proactive and reactive approach to deploying innovative technology for the delivery of LTSS CP Supports. The proactive approach will include assessing the technological capacity of enrollees. While some enrollees may be digitally savvy, others may function in a digital void so an all or nothing approach will not benefit the people we aim to serve. LTSS CP support staff will work to promote access to digital resources for enrollees whenever feasible.

A second feature of the proactive approach is vigilance in staying informed of emerging tools and technologies. FSA will stay engaged with other providers, using networking as an opportunity to stay ahead of new technology. FSA will strive to learn from enrollees as to best practices approaches and emerging trends and technologies. Sources such as the National Association of Social Workers and the Association of Social Work Boards are good resources for how emerging technologies can be deployed. The FSA IT Manager remains an active member of the CareLogic Electronic Learning Community which is another great source for identifying new tools.

FSA will also take a reactive approach to the use of innovative tools and technology. If a resource is identified, FSA will react by finding a way to utilize that resource. FSA will also react to suspend the use of any innovative technology that negatively impacts the quality of services, increases vulnerability or fails to meets it objective. With a balanced approach or learning, exploring and prudent risk management, FSA will appropriately deploy existence and emerging technology in support of CP services.

E. Personnel and Staffing

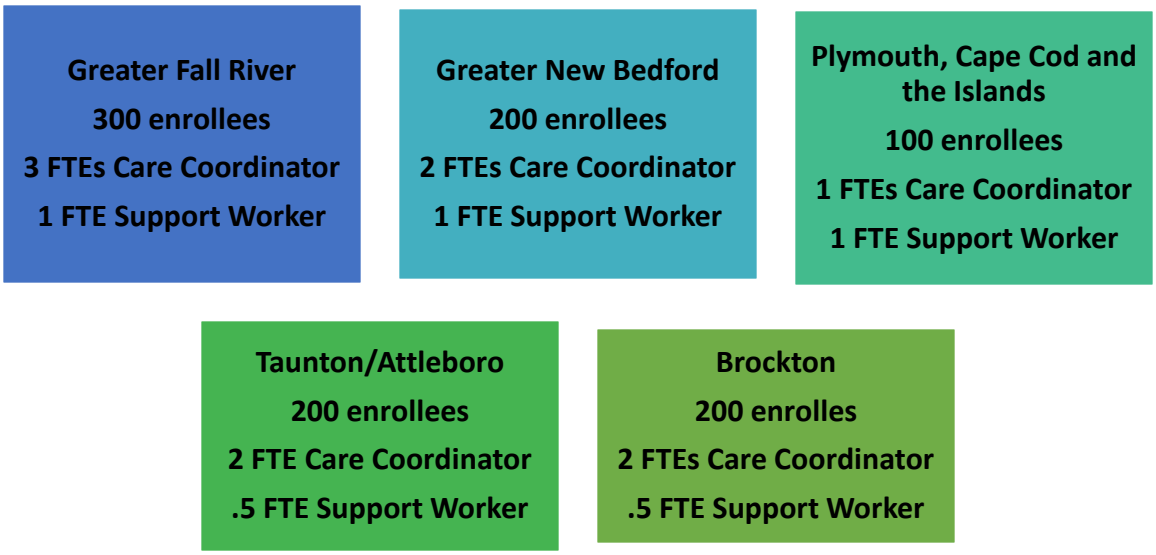
Staffing Model: FSA recognizes that it greatest resources is personnel. We are dedicated to recruiting, hiring, onboarding and developing staff that can provide the highest quality, mission-driven and culturally competent services to a diverse set of consumers. The staffing plan proposed to fully implement the required scope of CP Supports as well as administrative aspects of the contract includes existing internal resources and recruitment for new positions.

FSA proposes to create care coordination teams comprised of Bachelor's level Care Coordinators and Community Support Workers. Each team will be assigned to certain geographic regions and will include a dedicated number of Care Coordinators supported by a Community Support Worker. The Care Coordinators will be responsible for the delivery of the scope of services detailed in the contract including outreach, enrollee engagement, care planning, care team participation, LTSS Care Coordination, transitional care, health and wellness coaching, and connecting enrollees with social services and community resources. The Care Coordinators will assign tasks to the Community Support Workers to facilitate operations. For example, Community Support Workers may facilitate getting primary care providers signature on care plans, help with distributing care plans though secure email correspondence on behalf of the Care Coordinators, help with data entry and running performance reports, monitor EHR alerts for deadlines, coordinate logistics for Consumer Advisory Boards and network provider meetings, maintain minutes of meetings, and provider general support for the delivery of LTSS CP Supports.

FSA is bidding to serve the entire Southeast Region as defined by the RFR. We plan to create ~~four~~ five care coordination teams. One team will be housed in Fall River within FSA's current administrative headquarters. The Fall River team will serve the Greater Fall River area. The second team will be housed out of FSA's satellite office in New Bedford and will serve the Greater New Bedford area including Wareham. A third team will operate from FSA's Plymouth satellite location and will serve Plymouth, Cape Cod and the Islands. A fourth team will operate out of FSA's satellite location in Raynham and serve the Taunton and Attleboro areas. A fifth team will serve the Brockton area. This team will initially be housed in the Raynham office.

The staffing plan starts with seven FTEs for Care Coordinators, 3 FTEs for Community Support Workers, one FTE for a Care Coordination supervisor and one FTE for a Director of Healthcare Transformation. The start-up staffing plan and utilization of existing satellite locations allows FSA the flexibility to assign workers to regions once the contract is awarded and we have a clearer picture of what regions we will be assigned and the rate of enrollee assignment. It also provides sufficient resources to cover the entire region for which we are bidding. The team assigned to the Greater Fall River area will serve as back-up to both the Greater New Bedford and Taunton/Attleboro teams. By the third year of the contract, we expect to be at full capacity to serve 1000 enrollees annually and will grow the complement of Care Coordinators to 10 FTEs and the Community Support Workers to 4 FTEs.

The chart on the following page demonstrates the proposed staffing plan and geographic assignment by the third year of the contract:



Recruitment: FSA will follow a comprehensive recruitment plan to ensure that new employees for the LTSS CP Supports will adequately represent the communities served. A multifaceted approach includes on-line targeted advertising, college networking, local career centers, and word-of mouth referrals. FSA routinely uses an Applicant Tracking System, which provides an efficient and cost effective way to increase our on-line presence. The applicant tracking system connects FSA to Indeed, a world-wide employment-related search engine for job listings. Indeed reaches a large and diverse population and has historically provided a good pool of candidates. Indeed will be one on-line source, and will be supplemented by Monster and focused advertising to reach diverse populations. We will also use O Jornal, which is the ethnic division of The Herald News, located in Fall River. In the past we have had success with posting on other boards, such as Craig's List and Linked In, and will include that in our on-line resources to advertise and network. Additionally, FSA's Facebook presence and corporate website will highlight new opportunities.

FSA already works with several area colleges and universities to recruit culturally and linguistically diverse candidates with Associates, Bachelors and Masters level degrees. We work with Bristol Community College in Fall River, UMASS Dartmouth, Bridgewater State University, Rhode Island College, University of Rhode Island, and Community College of RI. FSA fosters close relationships with the local colleges, in an effort to increase internship placements, thereby increasing referrals and potential hires. On many cases we can connect to a target population (eg Spanish or Portuguese speaking) through affiliations with campus groups. Networking with Department Deans, posting on job boards, and attending Job Fairs have all been productive components of the college recruitment plans.

We also utilize the Career Center in Fall River that networks to the surrounding areas by posting FSA positions on their state website Job Quest. This too reaches a broad and diverse population. On-going relationships with career counselors are helpful in identifying possible candidates. The applicants from these locations are an excellent representation of the local community. Additionally, we are well connected to many different community organizations and have found success with word-of-mouth

referrals. Positions in the LTSS CP Supports will be made available to current FSA employees and generating word-of-mouth referrals from current employees will be incentivized through an Employee Referral Incentive Program.

FSA offers a very generous benefit package including excellent medical and dental insurance plans, short term and long term disability insurance, life insurance, and generous employer contribution to the 403B plan. Paid time off benefits provide employees a healthy work life balance, with 11 paid holidays, 10 days sick leave, and 3 weeks' vacation in the first year. Employees entering the organization with a Master's degree or higher start with 4 weeks of vacation and employees who stay for five years are also increased to four weeks of paid vacation. This comprehensive benefit package aids in recruitment and retention.

Competency: A consistent and rigorous screening process ensures candidates meet the competencies required by the Contract. This includes initial screening by Human Resources, face-to-face interview with the hiring Director and at least one additional round of interviewing with a member of Senior Leadership. All candidates must provide at least three references; two of which must be professional references who can attest to work experience and skills. FSA confirms all credentials submitted included licenses and degrees and a cross check of the excluded providers is completed prior to hiring. All candidates must all complete a criminal offender record information (CORI) screening and be approved for hire by the CORI officer.

To promote the continual development of the workforce, FSA offers a comprehensive training program. Driven by a training matrix assigned by Senior Leadership, employees are provided ongoing training on legally mandated topics and program specific subjects. Each program has a budget with allocated training resources. Employees have the flexibility to attend workshops, conferences and training opportunities as part of the work day with fees paid by FSA with prior approval. A consistent schedule of supervision provides individualize coaching and each employee receives and annual performance appraisal.

Retention: FSA recognizes that a thorough and interactive on-boarding process is an important aspect of employee retention. FSA provides an informative organizational orientation, specific program/department orientation, and thorough training throughout the orientation period. Additionally, recent enhancements to our onboarding program, including a 3 month survey, face-to-face meetings with Human Resources, and an annual follow-up survey, are all designed to receive valuable feedback on the onboarding experience, training, and overall communication.

Throughout their employment, employees receive ongoing training, regular partnership meetings (supervision) and various types of recognition and incentives, both directly from their leaders, as well as organization wide. FSA prides itself on a workplace culture that continually looks for ways to support, motivate, inspire and recognize talented workforce that serves its mission. FSA leaders consistently keep the focus on our mission, while ensuring they support and coach employees to remain energized and healthy, so they in turn are able to maintain that mission focus. This emphasis in training and supervision ensure our employees know that FSA cares about them as individuals. In the most recent employee feedback survey, 98.8% of employees responding to the survey agreed that FSA cares about the health and well-being of its employees.

FSA has an active Recognition Committee, which highlights the achievement of employees, departments or programs as they strive to meet our mission. Awards are given based on nominations from peers and leadership, and individuals or teams can receive this recognition.

7.5 INITIAL DSRIP PARTICIPATION PLAN

FSA offers generous benefits, which are consistently rated positively by our employees. Unlike many other non-profit organizations, FSA has provided annual wage increases to their employees for the past 15 years. Salaries have increased by 3-3.5% annually allowing FSA to remain a competitive employer. In addition to regular wage increases, FSA often provides bonuses to employees for recognition and appreciation. Another benefit that demonstrates FSA's commitment to its employees is its award – winning Worksite Wellness Program. Led by a team of volunteer wellness coaches, this program offers regular activities designed to support employee's physical and emotional well-being.

Family Service Association

101 Rock Street ❖ Fall River, MA 02720

508-678-7542 ❖ www.frfsa.org

Job Description

Position: Director of Healthcare Transformation

Program: LTSS Community Partner Supports

FLSA Status: Exempt

WCC Code: (8810)

Accountability: Chief Program Officer

Job Summary:

The Director of Health Transformation is responsible for the development and oversight of the Long Term Services and Supports (LTSS) and Community Partner (CP) Supports.

Duties and Responsibilities:

1. Develop an Outreach Plan to engage and educate members as to the benefits of enrollment.
2. Develop workflow process and documents in support of LTSS CP Supports.
3. Strengthen linkages between health care providers and community-based organizations that serve individuals with LTSS needs.
4. Develop a LTSS infrastructure (e.g. technology, information systems) reporting and monitoring mechanism that is sustainable over time.
5. Collaborate with ACO/MCO's to address the social determinants of health and breakdown existing silos to promote delivery of integrated care.
6. Create a program that supports person-centeredness, independent living, aging in place and cultural competence.
7. Oversee general program operations, ensuring that activities align with EOHHS policies.
8. Ensure workflow supports achievement of performance expectations including engagement of enrollees; development, approval and communication of care plans with care team members; and attainment of quality measures as determined by EOHHS.
9. Monitor data on program performance and make program/workflow adjustments in response to performance trends, and sustainability.
10. Research best and evidence based practices for member education, engagement and coordination of care.
11. Ensure staff development and training supports quality performance.
12. Create and sustain Consumer Advisory Board and provider network.
13. Appraise the performance of the supervisory staff.
14. Meets with Leadership Teams across the state to ensure that services are aligned and information is shared.

Education and Experience:

Must have a minimum of a LICSW or RN licensure. Experience providing social services, care coordination, LTSS and/or health care education.

Experience managing data and electronic health technology. Must have strong written and oral communication skills and demonstrated computer skills.

I have read, understand and accept the responsibilities outlined in this job description.

Signature: _____ **Date:**_____

Supervisor: _____ **Date:** _____

Family Service Association

101 Rock Street ❖ Fall River, MA 02720

508-678-7542 ❖ www.frfsa.org

Job Description

Position: Care Coordination Supervisor

Program: LTSS CP Supports

FLSA Status: Exempt

WCC Code: (8742)

Accountability: Director of Healthcare Transformation

Job Summary:

Under the direction of the Director of Healthcare Transformation, the Care Coordination Supervisor (CCS) serves as the supervisor of the LTSS CP Supports Care Coordination team. The CCS provides regular supervision for Care Coordinators and Community Support Workers and the delivery of all LTSS CP Support interventions.

Duties and Responsibilities:

1. Supervise Care Coordinators and Community Support Workers on a regular (no less than bi-weekly) basis using in group and individual settings.
2. Demonstrate knowledge and experience in the delivery of LTSS Supports and Care Coordination.
3. Ensure Care Coordinators develop person-centered care plans that reflect the voice and choice of assigned enrollees within required timeframes.
4. Ensure LTSS CP Supports care plans are endorsed by primary care providers and shared with all members of the enrollee's care team.
5. Demonstrate willingness to work with individuals with complex LTSS and BH needs.
6. Support the engagement of assigned enrollees within specified timeframes.
7. Promote achievement of Quality Measures for the LTSS CP Supports.
8. Support the development of Consumer Advisory Boards and provider networks.
9. Have a willingness and ability to work with ACOs, MCOs, state agencies, service providers and community organizations.
10. Willingness and ability to work flexible hours and across the geographic area served by the program.
11. Provide guidance to the care coordination team for the development of health and wellness coaching and current listing of community resources.
12. Participate in 24 hour on call coverage on a rotating basis.
13. Triage referrals and provide referral resource with accurate and timely availability of needed resources.
14. Maintain paperwork requirements for LTSS CP Supports in compliance with established timeframes.
15. Assist in the orientation of new employees and the ongoing professional development of all LTSS CP Supports employees.
16. Provide assistance to the Director in reporting and monitoring program performance.
17. Demonstrate and promote respectful, culturally competent and linguistically responsive delivery of services.
18. Understand and demonstrate commitment to agency mission, values and philosophy in performing job responsibilities, including compliance with all ethical and legal requirements of the organization.
19. Respond to reasonable expectations of the Director of Healthcare Transformation and the organization.

Education and Experience:

Must have a Master's degree in social work, human services\, nursing, psychology, sociology or related fields. Must have a minimum of three years of relevant professional experience. Must have the skills necessary to engage and work with others from diverse backgrounds. Maintain a nonjudgmental attitude toward families. Must be willing to work across the entire geographic region assigned to the organization and demonstrate willingness to work with yhe target population.

I have read, understand and accept the responsibilities outlined in this job description.

Signature: _____ Date: _____

Supervisor:_____ Date: _____

Family Service Association

101 Rock Street ❖ Fall River, MA 02720
508-678-7542 ❖ www.frfsa.org

Job Description

Position: LTSS Community Partner Care Coordinator
Program: LTSS Community Partner Program
FLSA Status: Non-Exempt
WCC Code: (8810)
Accountability: Care Coordination Supervisor

Job Summary:
The Long Term Services and Supports (LTSS) Community Partner (CP) Care Coordinator is responsible for promoting coordination in the delivery and receipt of LTSS to enrollees assigned by Accountable Care Organizations (ACO) and Managed Care Organizations (MCO).

Duties and Responsibilities:

1. Conduct outreach to assigned enrollees to inform about the functions of a CP Care Coordinator, the optional nature of CP enrollment, choice in CP providers, the benefits of enrollment and the process for enrolling.
2. Document all outreach attempts including 3 separate attempts; and at least one face-to-face attempt unless the enrollee voices a preference for only telephonic contact.
3. Execute all required documents for participation in the CP program including but not limited to a Participation Form and all required authorizations for Use and Disclosure.
4. Obtain the Comprehensive Assessment from the referring ACO/MCO and update as needed for any changes in functional status, ADL or IADL needs.
5. Utilizing the Comprehensive Assessment, and under the direction of the enrollee/authorized representative, develop a LTSS Care Plan that identifies preferences, goals, strengths, needs and cultural considerations and is signed by the enrollee/authorized representative. Complete updates to the LTSS Care Plan upon request of the enrollee, as needed due to major changes in functional, ADL or IADL status, and at least every 12 months
6. Ensure LTSS Care Plan is approved by the Primary Care Provider and shared with all members of the enrollees care team including providers, members of state agencies and other case managers within 90 days of assignment.
7. Utilize alternative methods and formats of documentation and communication to ensure the enrollee understand the LTSS Care Plan; including but not limited to accommodation for sensory disabilities, literacy and primary language of the enrollee.
8. Utilize appropriate interventions to engage and support the enrollee in development of the LTSS Care Plan including self-directed care options and informed choice for applicable services, programs and providers.
9. Assess enrollees for Social Services and resources including Flexible Services and facilitate access to Social Services and Community Resources.
10. Participate as a member of the enrollees care team, providing subject matter expertise to the care team about LTSS, the enrollee's needs, preferences and service options; advocating for appropriate care, facilitating communication with other providers and promoting integration of care across all spectrums.
11. Maintain regular contact with the enrollee and a minimum of one face-to-face contact quarterly to assist the enrollee to navigate and access needed services, providing ongoing monitoring of the implementation of the LTSS Care Plan and monitoring for changes in status including health, housing, natural supports and caregivers.
12. Provide support for transitions of care and facilitate the development of appropriate discharge plans as indicated.
13. Conduct follow-up within 3 business days following any transition in care and conduct a face-to-face visit with enrollees within 3 business days post discharge from any facility.
14. Provide health and wellness coaching in accordance with the LTSS Care Plan including symptom management, health risk factors and behaviors, health promotion and setting and achieving health and wellness goals.

15. Maintain all documentation required for the delivery of LTSS Community Partner services.
16. Foster and maintain collaborative relationships with Primary Care Providers, Social Service Providers and representatives from state agencies.

Education and Experience:
Must have a minimum of a Bachelor's Degree in social work, human services, nursing, psychology, sociology, or a related field; or, an Associate's Degree and at least year of experience in the field. Must have strong written and oral communication skills and demonstrated computer skills.

I have read, understand and accept the responsibilities outlined in this job description.

Signature: _____ **Date:**_____

Supervisor: _____ **Date:** _____

Family Service Association

101 Rock Street ❖ Fall River, MA 02720

508-678-7542 ❖ www.frfsa.org

Job Description

Position: LTSS Community Partner Support Worker

Program: LTSS Community Partner Program

FLSA Status: Non-Exempt

WCC Code: (8810)

Accountability: Care Coordination Supervisor

Job Summary:

The Long Term Services and Supports (LTSS) Community Partner (CP) Support Worker is responsible for providing support to the LTSS Care Coordinator to promote coordination in the delivery and receipt of LTSS to enrollees assigned by Accountable Care Organizations (ACO) and Managed Care Organizations (MCO).

Duties and Responsibilities:

1. Conduct outreach to assigned enrollees to inform about the functions of a CP Care Coordinator, the optional nature of CP enrollment, choice in CP providers, the benefits of enrollment and the process for enrolling.
2. Document all outreach attempts including 3 separate attempts, and the scheduling of at least one face-to-face encounter unless the enrollee voices a preference for only telephonic contact.
3. Schedule face-to-face meeting for enrollees with LTSS Community Partner Care Coordinator.
4. Prepare encounter packets with informational materials and all documents needed for enrollee engagement.
5. Obtain the Comprehensive Assessment from the referring ACO/MCO
6. Facilitate approval of the LTSS Care Plan by the Primary Care Provider and sharing with all members of the enrollees care team including providers, members of state agencies and other case managers within 90 days of assignment.
7. Provide support for the utilization of alternative methods and formats of documentation and communication to ensure the enrollee understand the LTSS Care Plan; including but not limited to accommodation for sensory disabilities, literacy and primary language of the enrollee.
8. Gather and maintain resource and reference materials for area providers of LTSS, including contact information and service availability in support of facilitating enrollee access to Social Services and Community Resources.
9. Support Care Coordinator's participation as a member of the enrollees care team, gathering required information related to the enrollee's needs, preferences and service options; facilitating communication with other providers and promoting integration of care across all spectrums.
10. Maintain regular contact with the enrollee under the direction of the Care Coordinator.
11. Provide ongoing monitoring of the implementation of the LTSS Care Plan and monitoring for changes in status including health, housing, natural supports and caregivers under the direction of the Care Coordinator.
12. Provide support for transitions of care under the direction of the Care Coordinator.
13. Gather materials, curriculum and current resources in support of health and wellness coaching for enrollees regarding symptom management, health risk factors and behaviors, health promotion and setting and achieving health and wellness goals.
14. Maintain all documentation required for the delivery of LTSS Community Partner services.
15. Foster and maintain collaborative relationships with Primary Care Providers, Social Service Providers and representatives from state agencies.

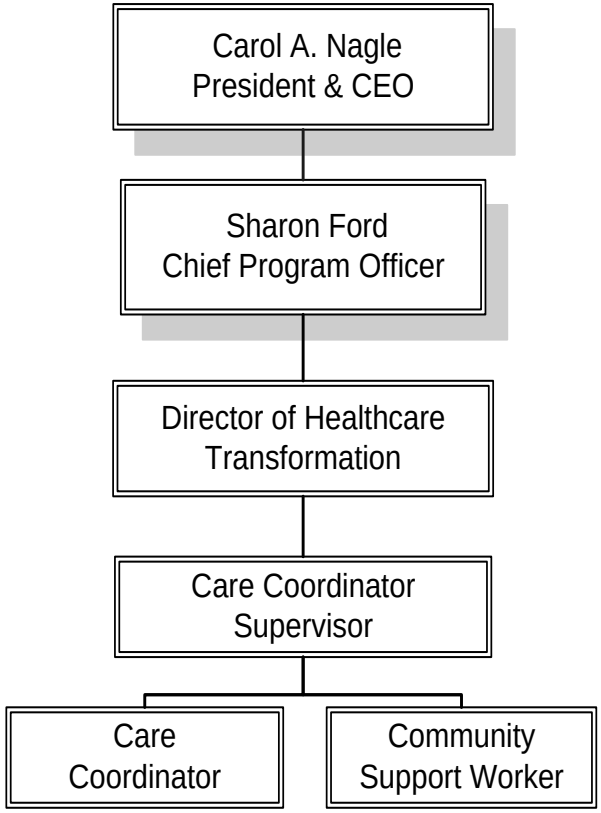
Education and Experience:

Must have a minimum of a High School Diploma and three years' experience in a related capacity. Must have strong written and oral communication skills and demonstrated computer skills.

I have read, understand and accept the responsibilities outlined in this job description.

Signature: _____ Date:_____

Supervisor: _____ Date: _____


Carol A. Nagle
President & CEO
Sharon Ford
Chief Program Officer
Director of Healthcare Transformation
Care Coordinator Supervisor
Care Coordinator
Community Support Worker

PREPARATION BUDGET PERIOD TIMELINE

December 2017

- Hire Director of Healthcare Transformation
- Secure consultant services for EHR customization
- Begin IT planning and purchasing of material good, determine EHR workflow
- Begin outreach and contracting activities with ACOs and MCOs

January 2018

- Start drafting recruitment plan
- Begin configuration of laptops, tablets, desktop adaptors and smartphones
- Assess satellite office capaxity to support LTSS CP operations
- Determine preliminary workflow process and infrastructure design

February 2018

- Source qualified internal candidates and recruitment for Program Supervisor
- Begin configuration of laptops, tablets, desktop adaptors and smarphones
- Purchase, receive and set up office furniture and equipment
- Explore and establish data sharing platforms with ACOs/MCOs

March 2018

- Hire Program Supervisor and begin onboarding/orientation
- Source internal candidates and begin recruitment for Care Coordinators and Community Support Workers
- Draft marketing plan including targeted advertising and promotional materials
- Test EHR customization & report writing, confirm EOHHS reporting

April 2018

- Finalize marketing plan; print brochures, flyers, community promotion and outreach materials
- Continue hiring, onboarding and orientation
- Complete website updates and initiate social media campaigns
- Job shadowing for Care Coordinators with ICCs and LTSS staff

May 2018

- Begin professional development plan, train staff on IHR and workflow processes
- Begin establishing Advisory/ Provider Network groups
- Finalize EHR workflow and test all sytems and reporting
- Prepare for readiness evaluation

I. Quality Management and Performance Monitoring

Quality Improvement Program: FSA continuously seeks to achieve excellence in service delivery, demonstrated through the application of its Quality Improvement Program (QIP). The program engages a systems-approach to quality management as it applies various methods of measurement and the skills and knowledge of the organization's employees to systematically evaluate and improve the overall environment. The program includes the consideration of internal and external systems, processes and data that measure performance, focusing specifically on what directly supports the agency's mission and contributes to meeting the needs of consumers. It recognizes the value of stakeholder contribution and incorporates feedback into improvement plans. Below is a description of the general infrastructure, processes and activities:

Long-term Planning	The Strategic Plan sets broad-based goals for quality improvement and promotes fidelity to the organization's mission, vision, and goals
Short-term Planning	Evaluates progress toward strategic goals with update and amendment to the Strategic Plan as needed.
Outcome Measurement	Outcomes are based upon standards set forth by licensing, regulatory, and accrediting authorities and best practice guidelines. All programs measure at least one of the following: change in clinical status; change in functional status; health, welfare, and safety; permanency of life situation; and/or quality of life indicators
Performance Improvement Targets (PIT)	Each program sets at least two PITs that are data-driven and intended to improve the quality of the program or address areas for improvement. PITs must be measurable and relevant to the services provided.
Feedback Mechanisms and Response/Action Plans	Ensures critical areas identified for improvement are addressed and resolved with feedback through the chain of command and to CQI
Stakeholder Participation and Feedback	Consumers in all programs are offered an opportunity to participate in anonymous feedback surveys each year. Feedback is incorporated into PITs and organizational goals as applicable. .
Case Record Review (CRR) and Utilization Review (UR)	CRR and UR uses peer review teams to evaluate the quality and appropriateness of care as well as the presence or absence of required documentation (legal and regulatory compliance). CRR and UR data is regularly monitored and analyzed and may be used for PITs and organizational goals
Internal Quality Monitoring	At least once each year programs undergo some form of objective review under the purview of the Director of Quality. The design and scope of the review is based on various factors, including industry trends, emerging risks, identified vulnerabilities etc.
Risk Management	Continual monitoring of adverse and/or unplanned events related to the delivery of services and consumer outcomes. Events of a serious nature are subject to internal review.

7.5 INITIAL DSRIP PARTICIPATION PLAN

Quality Initiative Year One: The Quality Initiative FSA proposes for the first year is to measure success at enrollee engagement and length of stay. It is recognized that under a per-member-per-month payment methodology, FSA must maintain a threshold of engaged members with Qualifying Activities each month for the LTSS CP Supports to remain sustainable. By setting this as the first quality initiative and continually monitoring the number of assigned enrollees who initially engage, the number who remain engaged, and average length of stay for enrollees, FSA can keep a watchful eye on outputs. This will also support monitoring of quality as it is reasonable to believe that quality service delivery will promote engagement and tenure. The better FSA staff become at outreach and engagement practices, the more likely enrollees are to engage and to remain engage.

It is anticipated that the rate of engagement will improve from one quarter to the next and that the last quarter would have both the highest rates of engagement and the longest enrollee tenure. We will also look at these markers by region as defined in the staffing plan and on a program-wide basis. The measures of success will be the number of assigned enrollees and the percentage engaged, with an expectation for improvement from quarter to quarter. FSA will also track reasons for disengagement and which may be attributable to factors outside the control of FSA (i.e. move out of state, death).

Functions of the QM Committee: The Administrative Quality Council functions as the quality management committee and provides support and guidance for the implementation of the Quality Improvement Plan. The Administrative Quality Council is chaired by the Director of Quality Improvement and meets at least bi-monthly. Membership includes at least the following departments, disciplines and/or programs; Quality Improvement, Administration, Nursing, Clinical Services, Elder Services, Support/Administrative Staff, Financial Services, Human Resources and off-site programming. The purpose of the Council is to ensure quality care and services are delivered to consumers by providing direction and assistance in the implementation of the organization's Quality Improvement Program. The Council reviews and provides recommendation regarding accreditation activities, organizational Policy and Procedure, Risk Management data analysis, internal and external reviews, outcome measurement systems and stakeholder feedback. The Council is driven by a charter. Minutes of each meeting are maintained and reported to the Senior Leadership Team which includes the President and Chief Executive Officer.

H. Sustainability: The sustainability of infrastructure and capacity building investments after the initial Contract Term will be contingent upon the rate of enrollee assignment and FSA's ability to perform Qualifying Activities as detailed in the Model Contract. Given that FSA operates a variety of programs with performance metrics, and given that FSA has a longstanding reputation for meeting and/or exceeding thresholds for performance, FSA is confident that we can complete sufficient Qualifying Activities to sustain the program. That assumption however is based on the rate of enrollee assignment, which is out of our control. FSA has built the program infrastructure for staged growth.

A system of checks and balances exists within FSA to monitor program performance and compliance with deliverables. The same system of checks and balances will be applied to the LTSS CP Supports. In this way, Leadership can effectively monitor performance on an ongoing basis and address shortfalls as they are identified. LTSS CP Supports will rely heavily on the configurable features of the EHR to support and monitor performance. FSA is making significant investments into the programming of the EHR's customizable features to design data entry, documentation, tracking and reporting modules. This is a substantial investment; however, once completed, will be fully operational using only internal resource within the IT department or within the LTSS CP Supports. This makes good use of infrastructure investments that will produce deliverables for the program that have no incurred cost once in production. As the workflow modules are built, the required, compliant choice will be the default choice. For example, enrollees will not move in the system from "assigned" to "engaged" until a signed participation agreement is entered. The system will have built in reminders for key activities to promote achievement of quality measures. An example of this can be seen in the execution of care plans. A reminder will be issued 60 days from enrollee assignment as a trigger to ensure care plans are completed within 90 days. Alert reports will go to Leadership for any enrollee that hits the 75 day mark without a fully executed care plan entered. The only other investment into the EHR is a per-user license fee. If the program operates at less than the required number of enrollees needed to meet the budget projections, fewer staff may be needed. In that case, FSA can easily will decrease the number of user licenses. After the initial infrastructure investment for programming and the user licenses, there is small allocation for additional EHR consultant time to provide any additional modules that may be needed related to start up and to facilitate communication with the ACO and improve our capacity to share and access information. Beyond these initial investments, there are no investments in tools, resources or processes that will require additional resources to remain sustainable.

FSA has a keen understanding of material costs and what it will take to keep the program operational. This understanding is built from having provided human services for so long and from having recently operationalized a number of effective programs including the Community Service Agency, Therapeutic Mentoring, In-Home Therapy and the Family Resource Center. In terms of material investments, such as computers, monitors, desks, file cabinets, telephones and the like, FSA has a budgeting format that dedicates a percentage of revenues each year to program needs to upgrade and/or replace material goods as needed.

Part of the infrastructure investment in the initial contract term is in Human Resources with the recruitment, hiring and training of employees. FSA has a succession plan in place for the key positions within the LTSS CP Supports. An internal candidate has been identified to serve as the Director to oversee the program. The individual is a seasoned member of the Leadership team with a diverse background. If the LTSS CP Supports do not receive sufficient referrals to be sustainable, FSA has the ability to utilize the Director in another capacity within the organization. The same is true for the Care Coordinators and Support Workers that will be brought in to serve in the program. Since care coordination is a hallmark of so many of FSA's existing services, staff can be absorbed by other FSA programs. On the other hand, if additional resources are needed for LTSS CP Supports that exceed the programs' current staffing capacity,

workers from other programs can be engaged to assist with the volume until sufficient staff can be recruited, hired and trained for the program.

The final, but probably most important element of the sustainability plan, is FSA's strong fiscal standing. FSA has sufficient operating reserves that can be applied to support the program as it evolves and begins to generate revenue.

J. Coordination with ACOs and MCOs

In FY 15, FSA began work with the Steward Health Care Network (SHCN) on a pilot project related to an Executive Office of Health and Human Services Infrastructure and Capacity Building Grant. The first successful pilot explored shared governance and enhanced organizational integration. The second pilot, which ran concurrently with the first, tested data integration, clinical informatics, and population-based analytics. Currently, FSA is working with SHCN on a clinical integration project that addresses avoidable emergency department (ED) visits. Thus far, using data provided by MassHealth we have successfully identified a cohort of individuals who were simultaneously serviced by FSA, attributed to a SHCN primary care provider and experienced one or more ED visits. The data provided was retrospective and looked back to 2015. FSA has been able to cross reference the data and identify which individuals remain attributed to SHCN and actively engaged in one or more FSA services. The next step in the project will be direct contact with the individuals to test the capacity to engage with members to provide consultation on the appropriate use of EDs and ensure follow=up and compliance with ED discharge plans. This final pilot is in the early stages but is already showing promise in the coordination of care.

It is FSA's intent to build upon the successful work with SHCN for the implementation of the LTSS CP Supports. That success lends credence to our capacity to work with ACOs and MCOs and will be leveraged in support of contracts with additional ACOs and MCOs. FSA already coordinates LTSS with areas hospitals so the skills and expertise of our staff is widely recognized. The successful partnership with SHCN and the progress we have made on the pilot projects will help confirm FSA's value to additional ACOs and MCOs. Currently FSA works with a number of SCOs in a variety of programs without any difficulty. The same is true of the Behavioral Health Center which contracts with a number of insurances and Medicare MCOs. The knowledge gained from these experiences in other programs can be applied in support of LTSS CP Supports.

The marketing and branding plan with respect to the ACOs and MCOs will be determined through consultation with the various ACOs and MCOs. FSA plans to begin designing a marketing plan in the second month of the Budget Preparation Period. The FSA Director of Marketing with work with the Director of Healthcare Transformation on coordinated marketing strategies with ACOs and MCOs.

The staffing plan proposed by FSA for the implementation of LTSS CP Supports will facilitate engagement and collaboration with multiple ACOs and MCOs. The plan outlines a strategy to create care coordination teams comprised of care coordinators and community support workers. Each team will be assigned to cover specific cities and towns in the areas FSA plans to serve. Similarly, care teams can be assigned to different ACOs and MCOs as a means of working with multiple providers are one time.

The strategy for conflict resolution will include open, honest and direct communication. Taking steps to prevent conflict from arising in the first place is an important first step. FSA intends to create a provider network group that will be similar to FSA's successful Systems of Care Committee utilized in the CBHI programs. The provider network will create an opportunity for workers to get to know each other and for information sharing. Representatives from MCOs and ACOs will be invited to participate in the provider network to help build rapport. Staying abreast of changes in eligibility criteria and protocols will prevent confusion and inconsistency which can lead to conflict. Making sure roles and responsibilities are clearly defined and consistent application of protocols and procedures will also help to build productive relationships. If conflict does arise, keeping the client at the forefront of discussion will create the common ground needed to start meaningful communication. If needed, the chain of command will be accessed and ACO and MCO staff will be encouraged to do the same.

K. Providing Culturally Competent and Informed Services and Supports

FSA intends to continue its tradition of providing effective, equitable, understandable, and respectful services that are responsive to diverse cultural beliefs and practice. We will continue to honor language, health literacy and communication needs as we have done for decades. FSA programs offer strength-based person/family-centered, culturally and linguistically responsive and trauma-informed services, in both center-based and outreach settings. Outreach settings where services may be offered include, but are not limited to, person's homes, schools, day care centers, nursing homes and adult day health centers. In keeping with FSA's mission, a diverse staff provides services in a culturally sensitive manner in the language of the consumer, wherever possible. Cultural competence is an expectation for all staff and on-going training is offered on this subject.

Multiple programs employ staff who speak Spanish, Portuguese, French and Hmong. This mirrors the primary languages spoken in the communities we serve. The agency also uses a language translation service that provides telephonic interpreter services for a variety of languages. Written materials needed for engagement are available in Portuguese and Spanish including participation agreements, statements of client rights and the FSA Privacy Notice. To ensure applicants are aware of the organization's capacity to accommodate different languages, materials in reception areas are posted in a variety of languages. Brochures and flyers for LTSS CP Supports will include a statement that materials are available in a variety of languages and that communication assistance is available. This statement will be included on all marketing and outreach materials.

FSA recognizes that people with speech and language challenges use a variety of ways to communicate. FSA is prepared to accommodate for the individual communication needs of every service applicant, including the use of technology in support of communication. The methods FSA will provide will vary depending on the abilities of the person and on the complexity and nature of the communication that must occur. Written notes may be effective for brief and relatively simple face-to-face communication. Written forms and information sheets may be sufficient in situations where there is little need for interactive communication. For more complicated communication, more sophisticated resources will be deployed such as assistive listening devices or the use of a qualified sign language interpreter.

Communication with individuals with cognitive disabilities involves determining their ability to understand spoken information and to read and comprehend written materials. Assumptions cannot be made based on the individual's verbal skills. Taking time to present materials in a manner that can be understood will foster good communication. Repetition, validation and verification of key facts along with following verbal instructions with written materials may also be helpful.

FSA provides services in a manner that is responsive to diverse cultural beliefs and practices, including those related to an individual's race, ethnicity, disability, sexual orientation and gender identity. This is achieved through a number of strategies. The first is through the recruitment and hiring process. Applicants for employment are advised of the population served by FSA and the expectation to demonstrate sensitivity to the service population's cultural and socioeconomic characteristics. The next strategy is the orientation or onboarding process. New hire orientation which includes an introduction to culturally competent care and establishes the expectation for respectful care. Every employee is required to attend culturally competent care training on an annual basis. Curriculum components include recognizing the changing demographics of our community, understanding the influence culture can have on the delivery of services and realizing the value of culturally competent care. Training is followed by supervision and coaching. Organizationally we also track effectiveness in providing culturally competent care through stakeholder feedback surveys.

The FSA workforce is experienced working with a diverse population. Highlights of FSA's work with the population specified is provided in the table below.

7.5 INITIAL DSRIP PARTICIPATION PLAN

Population	Expertise and Experience
Individuals experiencing homelessness	• Group adult foster care: collaboration with housing authorities throughout the service area to prevent evictions • Guardianship: applies legal, social and fiscal resources to prevent homelessness • Adult foster care: placement in a host home for individuals who cannot live independently in the community • Representative Payee program: ensure rents are consistently paid to prevent evictions and homelessness. Works with individuals who are homeless to apply fiscal resources to secure housing
LGBTQ Populations	• Community Service Agency: support and advocacy for LGBTQ youth. Specialized staff training to work with youth experiencing violence/bullying related to sexual identify • Behavioral Health Center: trauma-informed care to victims of violence related to sexual and/or gender identify • Family Resource Center: information and referral for LGBTQ populations in need of community resources • Adult foster care: specialized services for adults with HIV and AIDS
Criminal Justice involved individuals	• Community Service Agency, Therapeutic Mentoring and In-Home Therapy: services to youth involved with the juvenile justice system. • Representative Payee: allocate benefits to pay court cost, fines and legal fees • Behavioral Health Center: counseling and support to individuals facing legal challenges, impending incarceration and upon return to the community • Family Resource Center: specialized services to Children Requiring Assistance (Juvenile Justice involved)
Individuals who are blind, low vision, Deaf or hard of hearing	• Group adult foster care: in-home modifications to support individuals with sensory deficits; facilitates referral for additional community supports • Adult foster care: individualized education to host families/caregivers on meeting the needs of bling/deaf/hard of hearing individuals • Adult Day Health: program modification to ensure meaningful participation in program activities • Behavioral Health Center, Family Resource Center: accommodate communication needs for blind/deaf/hard of hearing individuals
Individuals with cognitive disabilities	• Group adult foster care: daily hands on assistance, meal prep and medication cueing • Adult foster care: safe and secure housing for individuals who can no longer safely live alone • Adult Day Health: therapeutic activities for individuals with cognitive impairments

Community Partner Program Budget Report

					GLSS				
	Program Revenue		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
	Estimated Enrollees- Start of Period (All Enrollees)			0	631	1,892	1,892	1,892	
	Estimated Enrollees - End of Period (All Enrollees)			1,305	1,892	1,892	1,892	1,892	
	Estimated Enrollees - Monthly Average			631	1,768	1,892	1,892	1,892	
	Total Estimated Program Revenue			**$ 353,360**	**$ 1,697,280**	**$ 1,816,320**	**$ 1,816,320**	**$ 1,816,320**	**$ 7,499,600**
	At- Risk Withhold Rate				0%	0%	0%	0%	
	Withhold funds				$ -	$ -	$ -	$ -	$ -
	Revenue for Operations			$ 353,360	$ 1,697,280	$ 1,816,320	$ 1,816,320	$ 1,816,320	$ 7,499,600
	Program Expenses		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
1	Salary		$ 54,475	$ 336,963	$ 990,933	$ 1,015,720	$ 1,015,720	$ 1,015,720	$ 4,429,531.67
2	**Fringe**		$ 15,798	$ 80,871	$ 237,824	$ 243,773	$ 243,773	$ 243,773	$ 1,065,811.35
	Total Personnel Costs		$ 70,273	$ 417,835	$ 1,228,757	$ 1,259,493	$ 1,259,493	$ 1,259,493	$ 5,495,343
3	**Training & Professional Development**		$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	**Travel**		$ 1,459	$ 4,089	$ 7,129	$ 7,314	$ 7,314	$ 7,314	$ 34,618
5	**Equipment**		$ -	$ 648	$ 1,130	$ 1,160	$ 1,160	$ 1,160	$ 5,258
6	**Supplies**		$ -	$ 1,121	$ 3,450	$ 3,540	$ 3,540	$ 3,540	$ 15,191
7	**Contract Services** (consulting, professional)		$ 13,500	$ 192,386	$ 398,188	$ 447,861	$ 325,796	$ 325,796	$ 1,703,527
8	**Software licensing**		$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	**Telecommunications**		$ -	$ 927	$ 2,599	$ 2,781	$ 2,781	$ 2,781	$ 11,870
10	**Occupancy** (rent, utilities, maintenance)		$ 27,230	$ 17,691	$ 51,558	$ 52,900	$ 52,900	$ 52,900	$ 255,179
11	**Other**		$ 250	$ 3,296	$ 5,750	$ 5,900	$ 5,900	$ 5,900	$ 26,996
	Total Direct Costs		$ 112,712	$ 637,992	$ 1,698,562	$ 1,780,949	$ 1,658,884	$ 1,658,884	$ 7,547,982
12	**Indirect Cost/Administrative Overhead**	**12.5%**	**$ 8,784**	**$ 52,229**	**$ 153,595**	**$ 157,437**	**$ 157,437**	**$ 157,437**	$ 686,918
	TOTAL EXPENSES		$ 121,496	$ 690,222	$ 1,852,156	$ 1,938,385	$ 1,816,320	$ 1,816,320	$ 8,234,900
	Surplus/Shortfall		*$ (121,496)*	*$ (336,862)*	*$ (154,876)*	*$ (122,065)*	*$ (0)*	*$ (0)*	*$ (735,300)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
LTSS Coordination Manager	$ 60,000.00	1.00	3.00	$ 15,000
LTSS Coordination	$ 41,600.00	4.00	1.50	$ 20,800
Senior LTSS Coordinator	$ 55,000.00	1.00	1.50	$ 6,875
Call Center Staff	$ 33,280.00	1.00	1.25	$ 3,467
Program/Admin Staff	$ 40,000.00	0.50	5.00	$ 8,333
Total Salary (Program Budget Line 1)		**7.50**		**$ 54,475**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 54,475.00	29%	$ 15,798
Total Fringe (Program Budget Line 2)			**$ 15,798**

Total Personnel*	**$ 70,273**

* Should align with Personnel Costs row in Program Budget

The above positions are related to direct program operations as opposed to infrastructure development and infrastructure management.

There will be **4 LTSS Certified Partner Coordinators** hired and trained prior to the start of year 1. These staff will coordinate care for up to 92 consumers, each. They will be hired at an annual salary of $41,600. Over the course of the first year, an additional 16 LTSS-CPC's will be hired in concert with caseload growth. The overall average FTE for the year, supported by the program budget*, will be 10.86, with the final number being 20.

There will **be 1 LTSS-CPC Supervisor** hired and trained prior to the start of year 1. This person will ultimately carry a caseload of up to 15 consumers and supervise 6 to 7 LTSS-CPC's. Over the course of year 1, 2 additional supervisors will be hired and trained, as the caseloads and number of LTSS-CPC's increase. They will be hired at a salary of $55,000. The overall average FTE over the course of year 1, supported by the program budget**, will be 1.68, with the final number being 3.

The **LTSS Coordination Manager**, (1.0 FTE @ $60000 for 3 months = $15,000), will be hired by the MSO in advance of the other program staff and will be involved in the hiring, training and oversight of all program staff.

Program/Admin Staff, (0.5 FTE @$40,000 for 5 months = $8,333), will provide administrative support to all members of the implementation team and will ultimately provide ongoing administrative support to the LTSS Coordination Manager.

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Total Training and Professional Development (Program Budget Line 3)			**N.A.**

Provide a description of each Training and Professional Development line item included in the table abovNot budgeted in the Project Budget for the Prep Period: *The training and professional development costs are not reflected in the program budget since theses services will be provided through the MSO and are reflected in the infrastructure budget. Ongoing training services beyond the infrastructure building period will be provided by the*

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
LTSS Coordination Manager	325	3	$ 0.53	$ 516.75
LTSS Coordinator	155	1.5	$ 0.53	$ 123.23
Senior LTSS Coordinator	147	1.5	$ 0.53	$ 116.87
Program Administrative Staff	265	5	$ 0.53	$ 702.25
			Total Mileage	$ 1,459.09

Travel Expense Description	Cost
Total Mileage	$ 1,459.09
Parking and tolls	
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ 1,459.09**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees. *LTSS Coordination staff will be distributed between 3 sites within the North Region. One site will be located in Lynn, one site will be located in Beverly and one site will be located in Lowell. The MSO site will be in Lynn. The LTSS Coordination Manager and the Administrative staff will be homebased in Lynn and traveling to the other sites to make sure that the locations are properly outfitted and that the new-hires are situated at their home base locations. Once hired, the LTSS Coordination staff will be travelling back and forth between their home sites and Lynn for trainings and staff meetings.*

Row 5 - Equipment

Description of Equipment	Unit Cost	#units or FTEs	Cost
Total Equipment (Program Budget Line 5)			**NA**

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined: *Computer and other digital devises will be supplied by the MSO as part of the infrastructure budget, during PBP. Initial office equipment and furnishings will be provided by the host sites as part of their occupancy cost reimbursement.*

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Total Supplies (Program Budget Line 6)			**NA**

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined: *Initial office supplies will be provided by the MSO during the PBP.*

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost

	A	B	C	D
140	**MSO- (Silver Otter Strategies)**	Subcontract	Management Servic	$13,500
141				
144				
145			**Total Contract Services (Program Budget Line 7)**	**$13,500**

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS. *During the PBP, the MSO will provide both capacity building services, covered in the infrastructure budget and ongoing management services, reflected in the Program budget. The role of the MSO is described in the PBP infrastructure budget narrative and in the RFP. The MSO will oversee and deliver: technology/communications, QA and Evaluation, Workforce Development, Fiscal and Administrative Supports, Workflow Design and Implementation, work site coordination and supports, Marketing, inter- and intra-organizational communications/connections, implementation of innovations (as*

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
		Total Software Licensing (Program Budget Line 8)	**N.A.**

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined: *Software licinsing costs will be paid based on consumer enrollment, starting in BP1. No license fees will be paid during PBP. All software related costs in PBP will be related to configuration and implementation. Those costs are reflected in the Infrastructure Budget.*

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
		Total Telecommunications (Program Budget Line 9)	**N.A.**

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined: *All telecommunication devises will be issued by the MSO. Any initial PBP costs during PBP will be absorbed by the MSO.*

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent			$ -
Utilities			$ -
Repair and Maintenance			$ -
	Total Occupancy (Program Budget Line 10)		**$ 27,230.00** **See Below**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined: *Each host site will be paid a flat fee during the PBP of $2,800 per FTE, for occupancy, to include rent, utilities, repairs & maintenance, office furnishings and access to office equipment.*

Row 11 - Other

Other Direct Expense Description	Cost
Miscellaneous	$ 250.00
Total Other Direct Costs (Program Budget Line 11)	**$ 250.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined: *$250.00 is budgeted for miscellaneous expenses, not otherwise anticipated.*

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead	**12.50%**	**$ 8,784**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined*: Indirect OH is based on 12.5% of personnel costs only.*

Community Partner Infrastructure Budget Report

		GLSS						
	Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
	PMPM Infrastructure Rate		$ 75.00	$ 49.72	$ 43.28	$ 36.40	$ 29.34	
	Engaged Enrollees		1,305	1,305	1,892	1,892	1,892	
	Estimated Infrastructure Funds		$ 685,125	$ 778,615	$ 982,629	$ 826,426	$ 666,135	**$ 3,938,930**
	At- Risk Withhold Rate			25%	44%	63%	81%	
	Withhold			$ 194,654	$ 432,357	$ 520,648	$ 539,570	**$ 1,687,228**
	TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 685,125	$ 583,961	$ 550,272	$ 305,777	$ 126,566	**$ 2,701,702**
	Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
	Technology							
1	**IT Staffing including Fringe**	$ 13,841	$ 15,167	$ 26,780	$ 27,583	$ 28,411	$ 11,705	**$ 123,487**
2	**Development Adaptation of EHR and/or Care Management System**	$ 230,000	$ 200,434	$ 200,434	$ 200,434	$ 71,699	$ 19,767	**$ 922,767**
3	**Technology for Service Delivery**		$ 10,000	$ 5,000	$ 2,000	$ 2,000	$ 2,000	**$ 21,000**
4	**Other Technology Expenses**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Technology	$ 243,841	$ 225,600	$ 232,214	$ 230,017	$ 102,110	$ 33,472	**$ 1,067,254**
	Workforce Development							
5	**Workforce Development staffing including Fringe**	$ 5,200	$ 9,260	$ 16,351	$ 16,842	$ 17,347	$ 8,934	**$ 73,935**
6	**Recruitment Expenses**	$ 5,000	$ 8,750	$ 5,000	$ 3,000	$ 3,000	$ 2,000	**$ 26,750**
7	**Training Expenses**	$ 2,000	$ 2,917	$ 5,000	$ 3,000	$ 3,000	$ 2,000	**$ 17,917**
8	**Retention Expenses**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Workforce Development	$ 12,200	$ 20,927	$ 26,351	$ 22,842	$ 23,347	$ 12,934	**$ 118,601**
	Business Start Up Costs							
9	**Office Equipment (PBP & BP1 only)**	$ 5,000	$ 5,000					**$ 10,000**
10	**Office Furniture (PBP & BP1 only)**		$ -					**$ -**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**	$ 121,496	$ 336,862	$ 154,876	$ 122,065			**$ 735,299**
	Total Business Start Up Costs	$ 126,496	$ 341,862	$ 154,876	$ 122,065	$ -	$ -	**$ 745,299**
	Operational Infrastructure							
12	**Operation Staffing including Fringe**	$ 54,297	$ 78,296	$ 138,248	$ 142,395	$ 146,667	$ 60,427	**$ 620,329**
13	**Other Operational Expenses**	$ 4,000	$ 5,600	$ 9,600	$ 9,600	$ 9,600	$ 9,600	**$ 48,000**
	Total Operational Infrastructure	$ 58,297	$ 83,896	$ 147,848	$ 151,995	$ 156,267	$ 70,027	**$ 668,329**
14	**Indirect Cost/Administrative Overhead Rate**	$ 9,167	$ 12,840	$ 22,672	$ 23,353	$ 24,053	$ 10,133	**$ 102,218**
	TOTAL INVESTMENTS	**$ 450,000**	**$ 685,125**	**$ 583,961**	**$ 550,272**	**$ 305,777**	**$ 126,566**	**$ 2,701,701**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
IT Director	$ 103,000.00	0.25	5	$ 10,729
	$ -	0		$ -
	$ -	0		$ -
	$ -	0		$ -
	$ -	0		$ -
	$ -	0		$ -
	$ -	0		$ -
	$ -	0		$ -
	$ -	0		$ -
	Total Salary	0.25		$ 10,729
	Fringe rate	29.0%	Total Fringe	$ 3,111
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 13,841**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

The IT Director, working for the MSO, will work with Thrasys and the MSO implementation team to configure and implement the Syntranet EHR system.

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Syntranet Implementation fixed fee	$230,000
Total Development and Adaptation of EHR and Care Management System (Infrastructure Budget Line 2)	$230,000

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Thrasys has quoted an all inclusive initial configuration and implementation fee of $230,000.00. This process will occur within the PBP.

Row 3 - Technology for Service Delivery

Description of Expense	Cost

	Total Technology for Service Delivery (Infrastructure Budget Line 3)	N.A.

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

There will be no costs incurred during PBP.

Row 4 - Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses (Infrastructure Budget Line 4)	**N.A.**

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

There will be no costs incurred during PBP.

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Trainer	$ 71,000.00	0.25	1	$ 1,479
Subject Matter Experts	$ 70,000.00	0.25	1.75	$ 2,552
	$ -	0		$ -
	Total Salary	0.5		$ 4,031
	Fringe rate	29.0%	Total Fringe	$ 1,169
Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)				**$ 5,200**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting

the terms of the CP's contract:

Subject Matter Experts, averaging 10 hours per week during the last 7.5 weeks of the PBP, will be employed by the MSO, from GLSS and each Affiliated Partner to cross-train all LTSS staff around disabilities, age and/or populationn specific issues likely to present among our anticipated consumer population, diversity in community contexts, aonflict-free case coordination, communication and other protocols, and effective data tracking/management/ and analytics..An internal MSO trainer, experienced in the delivery of enhanced LTSS coordination will assist in the training of all new staff and in the continuous training updates. This position will also be critical in delivering the training and supports that ensure a conisistent "LTSS CP" culture across partners.

Row 6 - Recruitment Expenses

Description of Expense	Cost
Advertising	$ 5,000.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 5,000.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

The MSO will conduct a multi-media/multipronged advertising and recruitment campaign for program staff during the PBP focusing on k

Row 7 - Training Expenses

Description of Expense	Cost
Outside Training Resources	$2,000.00
Total Training Expenses (Infrastructure Budget Line 7)	

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

In addition to the employed training resources, we are allowing for up to 25 hours at an average rate per hour of $80.00 for consultant trainers to deliver supports to staff around needs identified and not sufficiently covered in our ongoing LTSS CP Training program.

Row 8 - Retention Expenses

Description of Expense	Cost
Total Retention Expenses (Infrastructure Budget Line 8)	**N.A.**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

We do not anticipate any retention related expenses during the PBP.

Community Partner Infrastructure Budget Report - Business Start Up Costs - Prep Budget Period

Row 9 - Office Equipment

Description of Expense	Cost
All-in-one printer, copier, fax, scanner	$ 5,000.00
Total Office Equipment (Infrastructure Budget Line 9)	

Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were determined:

High speed multi-function office machine to be acquired by the MSO and shared by MSO LTSS-CP staff.

Row 10 - Office Furniture

Description of Expense	Cost
Total Office Furniture (Infrastructure Budget Line 10)	**N.A.**

Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:

To be supplied by host sites under occupancy reimbursement.

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Executive Director	$ 145,000.00	0.200	5	$ 12,083
COO	$ 62,000.00	0.200	5	$ 5,167
Director of HC Transformation	$ 141,440.00	0.125	5	$ 7,367
Director of Quality Management	$ 100,000.00	0.075	5	$ 3,125
Compliance Officer	$ 81,120.00	0.025	3	$ 507
CFO	$ 145,000.00	0.10	5	$ 6,042
Evaluation & Analytics Staff	$ 47,840.00	0.5	3	$ 5,980
Marketing Suppost	$ 43,680.00	0.25	2	$ 1,820
				$ -
	Total Salary	1.475		$ 42,090
	Fringe rate	29.0%	Total Fringe	$ 12,206
			Total Program Staffing including Fringe (Infrastructure Budget Line 12)	**$ 54,297**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract: Each of the below positions will be employed by the MSO:

The Executive Director of the MSO will provide executive level oversight of all program development and program infrastructure activities. **The COO** of the MSO will work directly with all of the below staff to assure timely implementation of all aspects of the infrastructure development. **The Director of HC Transformation** will oversee implementation of the enhanced LTSS coordination program design**. The Director of Quality Management** will assist in the operationalization of on ongoing monitoring of quality and outcome measures. **The Compliance Officer** will help to define all applicable regulatory and contractual compliance requirements and assure adherence to the same. **The CFO** will oversee the set-up and management of financial systems. **The Evaluation and Analytics** staff will work with QA and IT on setting up the business process for gathering and analyzing data, to measure outcomes and develop predictive analytics. **Marketing Support** will assist in the development and publication of all program informational and educational documents and brochures.

Row 13 - Other Operational Expenses

Description of Expense	Cost
Legal Consultation	$ 4,000.00
Total Other Operational Expenses (Infrastructure Budget Line 13)	**$ 4,000.00**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Converting current Management Agreements, in the for of MOU's, to long-term contracts. Developing written agreements with other entities, as needed.

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**12.50%**	**$ 9,167**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

This overhead rate is applied to personnel costs only, not to total direct program expenses. It includes all corporate level support costs, including, but not limited to Accounting and finance, HR, IT, board expenses, Audit fees, D&O insurance, etc.

Community Partner Infrastructure Allocation Worksheet

	GLSS						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL FUNDS AVAILABLE	$ 450,000	$ 685,125	$ 583,961	$ 550,272	$ 305,777	$ 126,566	$ 2,701,702
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
MSO- Silver Otter Strategies	$ 244,730	$ 227,496	$ 235,562	$ 233,465	$ 105,661	$ 34,935	$ 1,081,849
Affiliated Partner or Consortium Entity	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Affiliated Partner or Consortium Entity	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Affiliated Partner or Consortium Entity	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ 244,730	$ 227,496	$ 235,562	$ 233,465	$ 105,661	$ 34,935	$ 1,081,849
Workforce Development							$ -
MSO- Silver Otter Strategies	$ 12,850	$ 32,502	$ 28,395	$ 24,947	$ 25,515	$ 14,051	$ 138,260
Affiliated Partner or Consortium Entity	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Affiliated Partner or Consortium Entity	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Affiliated Partner or Consortium Entity	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Affiliated Partner or Consortium Entity	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ 12,850	$ 32,502	$ 28,395	$ 24,947	$ 25,515	$ 14,051	$ 138,260
Business Start Up Costs							$ -
MSO- Silver Otter Strategies	$ 5,000	$ 5,000	$ -	$ -	$ -	$ -	$ 10,000
Greater Lynn Senior Services	$ 40,778	$ 108,814	$ 51,625	$ 40,688	$ -	$ -	$ 241,905
NEARC	$ 40,779	$ 108,815	$ 51,625	$ 40,689	$ -	$ -	$ 241,908
Bridgewell	$ 40,779	$ 108,815	$ 51,625	$ 40,689	$ -	$ -	$ 241,908
Affiliated Partner or Consortium Entity	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ 127,336	$ 331,444	$ 154,875	$ 122,066	$ -	$ -	$ 735,721
Operational Infrastructure							$ -
MSO- Silver Otter Strategies	$ 65,084	$ 93,683	$ 165,129	$ 169,794	$ 174,601	$ 77,580	$ 745,871
Affiliated Partner or Consortium Entity							$ -
Affiliated Partner or Consortium Entity							$ -
Affiliated Partner or Consortium Entity							$ -
Affiliated Partner or Consortium Entity	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ 65,084	$ 93,683	$ 165,129	$ 169,794	$ 174,601	$ 77,580	$ 745,871
TOTAL INVESTMENTS	$ 450,000	$ 685,125	$ 583,961	$ 550,272	$ 305,777	$ 126,566	$ 2,701,702

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Development and Adaptation of E.H.R/Care Management System	Install Thrasys Syntranet as primary database/communications platform	12/01/17	05/31/18	LTSS CP database parameters established	Database captures, stores, and manipulates data according to specs			Syntranet communicates effectively with affiliated partner database systems	Effective portals are established for entering and retrieving data between different systems		
Technology	Development and Adaptation of E.H.R/Care Management System	Train staff on Syntranet	03/01/18	12/31/22	Key staff are trained	Key staff demonstrate competence in using full range of syntranet features			All appropriate LTSSC and MSO staff are trained in use of syntranet	All trained staff demonstrate competence in using full range of syntranet features		
Technology	Technology for Service Delivery	Establish inter-operability with ACOs/MCOs	03/01/18	02/28/19	Agreement established with at least one ACO to develop interoperable capabilities	NRLP and at least one ACO can exchange data through Syntranet platform			GLSS and ACO agree on IT requirements and workflows for interoperability and data sharing	Signed MoU between GLSS and ACO outlining interoperability/data sharing protocols involving Syntranet platform		
Technology	Other Technology Investments	Establish and launch predictive analytics capacity	03/01/18	12/31/22	Framework developed for identifying and measuring Social Determinants of Health	Theoretical model with appropriate hypotheses, variable relationships, and indicators established			At least one predictive analytics model developed capable of identifying appropriate "positive deviance" relative to improved health outcomes around one or more chronic diseases	Model is developed and shared with ACO partners		
Workforce Development	Recruitment	establish and implement uniform and unified recruitment and hiring capacities across all partner entities	01/01/18	12/31/22	uniform and unified policies established including appropriate protocols around NRLP recuritment, hiring, and retention	Policies are written and approved			Protocols and guidelines implemented to hire first group of new staff	Staff are hired using uniform and unifed procedures		
Workforce Development	Training	establish and implement comprehensive training that distinguishes NRLP LTSS capacities	01/01/18	12/31/22	Comprehensive curriculum developed for "LTSS Institute"	Curriculum exists for all identified topics in multiple formats addressing multiple learning styles; curriculum has been approved by SMEs and each partner entity			NRLP staff trained on curriculum	Staff demonstrate competencies on curriculm assessments		
Workforce Development	Retention	Establish an atmosphere of learning and best practice as key to retention strategy	01/01/18	12/31/22	Establish change and best practice culture for NRLP	Change campaign is developed with timelines and benchmarks			Change campaign is implemented	Change campaign begins to be assessed according to pre-established timelines and benchmarks		
Workforce Development												
Business Start Up Costs	Office Equipment	Establish LTSSC base sites in Lynn, Beverly, and Lowell	01/01/18	05/31/18	Sites are secured and at least one site is properly outfitted to receive NRLP staff	all facility arrangements are legally finalized; first site is available for new NRLP staff			All sites are properly outfitted to receive NRLP staff	all facility arrangements for each of the three sites are legally finalized and each is available to receive new NRLP staff		
Business Start Up Costs	Office furniture	Establish LTSSC base sites in Lynn, Beverly, and Lowell	01/01/18	05/31/18	Sites are secured and at least one site is properly outfitted to receive NRLP staff	all facility arrangements are legally finalized; first site is available for new NRLP staff			All sites are properly outfitted to receive NRLP staff	all facility arrangements for each of the three sites are legally finalized and each is available to receive new NRLP staff		
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Other Operational Expenses	Develop formal NRLP policies in accordance with model contract	01/01/18	05/31/18	Draft completed of NRLP policies completed and ready for circulation to Executive Committee	Draft is completed			All requisite NRLP policies are reviewed, revied as appropriate, and formally adopted by Executive Committee	Publication of official NRLP policies		
Operational Infrastructure	Other Operational Expenses	Develop formal QA/QI Plan	03/01/18	05/31/18	Outline of QA/QI plan developed and prepared for circulation to QA and Executive Committees	Draft of Plan with clear metrics is developed and ready for circulation			QA/QI Plan is approved	QA/QI plan becomes template for preliminary data analytics		
Operational Infrastructure	Other Operational Expenses	Develop ACO MoUs	01/01/18	05/31/18	Outreach and conduct negotiations with all appropriate ACOs in the region, establishing a comprehensive draft MoU outlining key elements for LTSS best practices	Draft MoUs established			MoUs are signed and implemented	MoUs reflect adequate datasharing, communications, and analytic collaboration		
Operational Infrastructure	Other Operational Expenses	Implement Marketing Strategies	02/01/18	05/31/18	Identify target sites for outreach and networking	Targets established in all North region communities			Marketing materials, collateral and overall campaign (including social media as well as other virtual technologies) is established and launched	Using various recognition metrics. NRLP visibility significantly increases		

PLEASE NOTE CHANGES IN PBP TIMELINE ON PAGE 51.
The Original Attachments B and C are not included here as they are superseded by the CP Workbook

7.5 Initial DSRIP Participation Plan

A. Executive Summary (*NOT TO EXCEED 2 PAGES*)

1. Goals, Challenges, and Solutions

The principal **goals** for the NRLP five-year business plan include:

- To develop a comprehensive and unified LTSS Coordination capacity across the Northern region that actively promotes the *Community First* agenda for all identified focus populations and that adheres to the values of conflict-free management.
- To create stronger pathways and connections among community resources and services that promote greater consumer choices and easier navigation, eliminate silos, and support the principles of community livability for all.
- To create a strong and dynamic training system for LTSS Coordination staff that fosters best practices in the delivery of all elements of the LTSS CP function.
- To develop a comprehensive quality management system that provides timely feedback and comprehensively supports best practice and cost-effective operations for all elements of the LTSS CP function.
- To develop seamless communication systems across LTSS providers, between LTSS providers and health providers, and with EOHHS and meets all EOHHS requirements as stated in the Model Contract.
- To establish and effectively maintain a value-based resource and LTSS provider capacity and performance database.
- To identify, pilot, and disseminate appropriate promising technology and other innovations that support greater consumer access and choices relative to *Community First* and community livability principles.
- To strengthen clinical-community linkages to support better health and lower health care costs for all identified focus populations.
- To develop appropriate indicators, rigorously capture the relevant data, and consistently measure the impact of the LTSS CP function relative to consumer health behaviors, status, and health care costs.
- To fully establish the critical value-add which best-practice LTSS Coordination brings to the health care system both in its capacity to address the social determinants of health and its impact in lowering the total cost of care for the focus populations.

The key **challenges** which the NRLP anticipates as its five-year plan unfolds involve the following:

- Creating a uniform, dynamic, best-practice "LTSS Coordination" culture across the NRLP LTSS CP operations.
- Developing unified communications, data reporting, and data sharing system.
- Establishing a cohesive value-based system to measure LTSS provider and other community resource capacities and performance.
- Developing and implementing a "real time" quality management system
- Strengthening clinical-community linkages
- Aligning community resources to facilitate easier consumer access and navigation.
- Establishing critical indicators for LTSS Coordination that are reliable, measurable, reflect social determinants of health, and demonstrate impact.

The NRLP, using principles of intentional design, proposes this LTSS CP partnership with the aim of integrating the innovative capacities of each member and of the LINK to address the critical barriers currently precluding integration of health and LTSS services. **Solutions** strategies towards that end include:

- Developing a comprehensive training component for LTSS Coordination that includes required learning modules (and certification of completion) around critical areas of subject matter expertise (*Community First* principles; motivational listening, and other proven approaches to optimizing self-determination and engagement; person-centered/person-driven supports, community diversity and context issues; conflict-free case management; diverse focus population characteristics and needs; understanding of disabilities and chronic disease issues; care planning, implementation, monitoring; principles of value-based referrals; social determinant of health and quality measures; approaches to health and wellness coaching, etc.) to develop a uniform best practice LTSS Coordination capacity.
- Embedding LTSS Coordinators/Liaisons in ACO Health Care facilities to strengthen clinical-community linkages.
- Designing workflows, protocols, and key objectives in tandem with quality management systems to generate opportunities for real time analysis and ensure QM is fully integrated into all aspects of the LTSS CP system.
- Implementing Thrasys/S*yntranet* communications and data system as a meaningful use certified EHR inter-operable platform to utilize capacities of existing systems, ensure appropriate communications with ACOs, health and behavioral health providers, social service providers, and EOHHS to support and facilitate overall LTSS CP functions.
- Exploring the potential to establish an After-Hours Call Center to support LTSS functions – facilitating greater consumer access, providing "reminder" calls, etc. to avoid missed appointments, connecting with late shift providers to better align community resources.
- Working with the LINK to establish appropriate forums to focus on expansion of No Wrong Door access through NRLP to better align community resources.
- Exploring use of existing GLSS caregiver app as well as working with SeniorLink's VELA app to help consumers better navigate community resources.
- Harnessing the power of the Kiosks for Living Well to support health and wellness coaching and for expanded populations and communities to promote stronger clinical-community linkages, consumer engagement, and consumer health outcomes.
- Using NRLP's ongoing evaluation research around *One Care* to design data capture mechanisms and analytics around the impact of LTSS Coordination functions to better demonstrate value and promote stronger clinical-community linkages.

2. **NUMBER OF ASSIGNED AND ENGAGED ENROLLEES BIDDER INTENDS TO SUPPORT:**

The NRLP expects to support **2365** assigned enrollees, which represents 53% of the identified FFS LTSS population in the Northern Region. We estimate the number that will be engaged at any one point in time will be **1892** (80%).

3. **SERVICE AREAS: ALL SERVICE AREAS IN THE MCO NORTHERN REGION**
4. **BIDDER'S PLAN TO OPERATIONALIZE LTSS CP:** *Please see 7.5F*

B. Supporting Populations and Community Engagement (*not to exceed 2 pages*)

1. Current Connections

GLSS, through the LINK and other networks, has partner connections with over 100 organizations throughout the North service area, regularly participates in partner meetings which these different networks convene, and can use networks such as the LINK as a foundation for further outreach. The LINK, for example, maintains a listing of advocacy, housing/shelter, LTSS providers, and social service organizations across the region and can facilitate access to many diverse organizations. Similarly, NRLP members have cultivated key relationships in the service areas of the Northern region, including:

- **Bridgewell:** Bridgewell works closely and enthusiastically with many other nonprofit and minority organizations to seek comprehensive and holistic solutions to the needs of people with disabilities and other life challenges. Bridgewell actively participates with various home health care agencies, Care Dimensions, community health centers, physicians and inpatient hospitals in over 24 communities in the Northern Region and is an active member of trade organizations such as Association of Developmental Disabilities providers (ADDP), Providers' Council, ABH and ARC Mass as well as the Lynn Non-Profit Business Partnership, Chamber of Commerce in Lynn, Peabody, Salem and the North Shore, Lynn Housing Authority and Neighborhood Development, Non-Profit Alliance of Greater Lowell and various other forums around Massachusetts that advocate for people with disabilities. We are a major contributor to the mainstream Continuum of Care networks in Lynn and Lowell which includes representation from local social service agencies.
- **GLSS:** GLSS has contractual connections with approximately 50 different LTSS provider entities which serve populations across multiple service areas, work in multiple coalitions across the region including Lifetime Care Solutions, Inc., co-chairs RCC which brings together regional transportation and human services organizations to do further networking, and maintains region-wide Mobility Links data base which includes information on a variety of entities who provide diverse services and supports.
- **NeArc:** NeArc works closely and collaboratively with many other nonprofit and minority organizations to seek comprehensive and holistic solutions to the needs of people with disabilities. Northeast Arc actively participates with various home health care agencies, Care Dimensions, community health centers, physicians and inpatient hospitals in over 100 communities in the Northern Region, is an active member of trade organizations such as Association of Developmental Disabilities providers (ADDP), Massachusetts Council of Human Service Providers, Massachusetts Day Hab Coalition, and Arc Massachusetts, and is a member of the Peabody Cultural Collaborative, North Shore Chamber of Commerce and local chambers. Northeast Arc also works with Housing Authorities in Swampscott, Salem, and Lynn and has partnerships with Salem State University, North Shore Community College, and the United Way, among many others.

2. Growing Connections

The NRLP will use the extensive networking connections of both the LINK and its member entities to further expand its capacity to identify, partner with, and appropriately catalogue new community connections. Using the capabilities of *SyntraNet,* NRLP will develop a centralized and user-friendly database of these resources, which will be updated regularly by Call Center staff who will receive appropriate training in techniques for building dynamic inventories. To further ensure comprehensive connections, the NRLP will work with key subcontractors who will provide expertise around community networking in their area for specific populations and community contexts. Such expertise will include training for NRLP staff on community history and contexts, introductions to community leaders and

consumer advocates, access to organizational networks, co-sponsored informational events or workshops, and other outreach techniques. Two such subcontractors,[1] will be EMARC and NuPath, which are briefly described below.

- **EMARC:** Since 1954, East Middlesex Arc's mission has been to support, serve and advocate for people with developmental disabilities and their families to ensure they are valued and respected members of their communities. Notably, East Middlesex Arc (EMARC) provides comprehensive Family Support Services including After-school programs, a broad range of targeted Recreation services, Adult Family Care, and Transition Support services throughout many Metro-North communities in particular, to the city of Malden. The family support program is led by an expert team of Master's level social workers and Registered Nurses that assess, support and coordinate care for the hundreds of individual and families served. Through a continuum of services including our Beverly Day Habilitation--"Life Choices Program"--and our In-Home Support services, EMARC works in concert with its sister agencies to maximize each individual's independence within the community, and support their ability to maintain and enhance essential daily living skills. EMARC[2] is headquartered in Wakefield, and also provides a continuum of residential and employment services to more than 1,000 individuals and their families each year.
- **NuPath:** Based in Woburn, MA, and offering services at locations across Eastern Massachusetts, NuPath serves 450 individuals and is proud to be part of a growing network of regional agencies changing the way the wider world views people living with disabilities. Program services provide education, coaching, opportunity and success, and include Day Services (Employment Supports, Community Based Day Supports and Day Habilitation); Residential Services (Autism residential Supports, Shared living, Independent Supports); Autism Focused Programs that address the unique and expanding needs of people living with Autism Spectrum Disorders; Clinical Services and transportation services that include a fleet of modern vehicles to meet the transportation needs of the people in programs.

3. Plans to Ensure Staff Maintain Up-to-Date Information

The NRLP will establish a centralized database using the *SyntraNet* platform to incorporate existing community resource / LTSS provider inventories and build new and more comprehensive information features that include quality measures. The platform will generate electronic update reminders to organizations in the database on a regular basis to verify descriptive information, and notify database administrators when responses are not forthcoming, which will then prompt the administrator to initiate appropriate telephonic inquiry to gather the information. Requests for information updates from participants will be a regular feature of LINK and other collaborative meetings. *SyntraNet* will produce periodic analytic reports identifying community resource/LTSS provider performance around identified indicators including consumer satisfaction, care plan progress, provider responsiveness, value-adds, and so forth.

Staff will have full access to this centralized inventory to support care planning, implementation and monitoring and will be trained on using this tool as part of their general orientation to the NRLP LTSS Coordination role.

[1] Pending EOHHS approval. All subcontractors will adhere to all terms and conditions as outlined in the Model Contract, including HIPAA provisions.

[2] EMARC is licensed and certified by the MA Department of Developmental Services, is a certified MassHealth provider and accredited by CARF.

C. COMMUNITY PARTNER SUPPORTS AND ACTIVITIES (*NOT TO EXCEED 10 PAGES*)

1. OUTREACH:[3]

The NRLP will accept all assigned enrollees to the fullest extent of its capacity and will confirm receipt of the assignment to EOHHS or the assigning ACO/MCO within one business day. After receiving notification of an assigned enrollee to the NRLP LTSS CP, an LTSS Coordinator will seek to make contact with him or her through telephone call and/or text, letter and/or email (if possible) and/or a face-to-face visit. Each of these modalities will be tried at least once, but there will be a minimum of two phone calls and one face-to-face effort, unless the enrollee indicates a preference for phone rather than in-person contact. All attempts to reach an enrollee will be fully documented.

a. Planned strategies to locate and engage with Assigned enrollees w complex LTSS needs

Through its various programs and initiatives, the NRLP offers extensive experience in locating and engaging with Assigned Enrollees with complex LTSS needs who are not easily reached. While protecting confidentiality, these strategies are designed to alert assigned enrollees to the LTSS CP opportunity. Some proven outreach strategies which the NRLP will incorporate in its role as an LTSS CP include those listed below. All outreach and informational materials and mechanisms will be submitted to EOHHS for prior approval before implementation.

- Developing an "Outreach Task Force" among LTSS Coordination staff who regularly contact (including in-person visits) shelters, soup kitchens, food pantries, community centers, clinics and health centers, faith-based organizations, potential gathering sites (e.g., coffee shops, fast food places), the Kiosks for Living Well sites, schools, employment support centers, etc. to connect with potential assigned enrollees and describe the opportunity for LTSS supports. The Task Force will also provide short presentations to community and consumer advocacy groups on a regular basis and broader presentations about LTSS CP Supports in more formal educational forums, including *Conversations for Caring*[4] LINK Partner Meetings, and other Regional meetings.
- Disseminating written information in appropriate languages and formats about LTSS CP Supports through various outreach workers, including Mental Health, Nursing, and Care Management staff employed by the NRLP, who are routinely in diverse corners of communities. This information will include directions on how to identify whether or not the individual is an assigned enrollee.
- Publicizing LTSS CP Support opportunities using accessible "post card" flyers that are left at pharmacies, clinics and health centers, targeted employment sites, local RMVs, Department of Transitional Assistance offices, schools, and community gathering sites.
- Developing Public Service Announcements about LTSS CP supports and the importance of connecting with assigned enrollees and arranging to appear on various Public Media broadcasts to describe the LTSS CP and the effort to reach assigned enrollees who may be difficult to contact.
- Establishing a social media presence with consistently engaging messaging around LTSS CP.
- Securing sponsorships to "wrap" vehicles with appropriate messaging about LTSS CP supports.

[3] Reports on all Qualifying Activities as described in 7.5C.1-7 will be documented in the database in the format specified by EOHHS and provided to EOHHS in the form, format and frequency required by EOHHS.

[4] Conversations for Caring, a GLSS program, is a monthly forum delivering "information from the field" around critical topics relative to health and well-being which has an active mailing list of over a thousand and features regular presentations in Lynn, Beverly/Peabody, and Chelsea (Soldier's Home).

Once the NRLP connects with the assigned enrollee, the LTSS Coordinator will provide information about the LTSS option and the supports this entails, including a description of the Coordinator role. The Coordinator will inform the assigned enrollee about his or her right to refuse LTSS CP supports, the choice to enroll in the NRLP and select a different Coordinator, and the choice to enroll in a different LTSS CP. Should the assigned enrollee choose to receive LTSS CP supports, the Coordinator will outline the enrollment process which begins by explaining the purpose of the Enrollee Participation Form and clarifying that the assigned enrollee's signature confirms his or her consent to participate in the LTSS CP program. As part of this conversation, the Coordinator also identifies the nature of "protected information" that will be asked from the assigned enrollee and explains how this will be used to provide LTSS supports. The Coordinator will then request the assigned enrollee's – or authorized representative – to sign the Participation Form. When appropriate, the Coordinator will also request that the assigned enrollee – or authorized representative – sign a written authorization to use the assigned enrollee's protected information as necessary in the provision of LTSS CP supports. Once the Participation Form is signed by the assigned enrollee, a copy is maintained in the assigned enrollee record and a permanent NRLP CP Coordinator (which may or may not be the same Coordinator facilitating enrollment) is assigned within 5 business days. This step initiates the LTSS Care Planning phase.

2. LTSS CARE PLANNING

As described in the Model Contract, the NRLP will receive the Comprehensive Assessment results from the ACO/MCO. Where these results do not appear to accurately reflect the enrollee's functional status, the NRLP CP Coordinator will notify the ACO or MCO. Using the most accurate assessment possible, the NRLP CP Coordinator (CPC) will develop a care plan under the direction of the enrollee (and/or authorized representative) that will address identified needs and which will be regularly updated to reflect progress towards goals as well as any changes in status. All plans will be uniquely designed for each enrollee; written and documented in the EOHHS-required format[5] and entered into the NRLP CP database system, translated and explained in the enrollee's primary language and also prepared in alternative media formats when necessary and as appropriate to ensure that all legally competent enrollees have full understanding of the plan; reflect results from the Comprehensive Assessment and other NRLP assessments; clearly identify the enrollee's goals, preferences, strengths and challenges as well as cultural context; be signed by the enrollee or authorized representative and shared with the enrollee's PCP and shared with members of the enrollee's Care Team and others providing supports, all of whose contact information is included.

The care plan will uniquely represent each enrollee and will shift to appropriately reflect changes in the enrollee's status, needs, and preferences. Including a cohesive overview of the enrollee's strengths and challenges, interests and personal goals, the plan will also address his or her service goals and the choices he or she considered for addressing each of these as well as the accommodations provided to support enrollee decision-making. The plan will also include a section reflecting strategies that the enrollee can use to address service-related issues that are not a part of the plan's basic framework as well as back-up arrangements for recommended or ongoing

[5] Stored data will include date of contact, mode of contact, person contacted, results of contact, CPC electronic signature, results of all assessments including for flexible benefits, demographic information. All EHRs will be current and maintained in accordance with EOHHS standards and, upon request, the EHR will be provided to EOHHS within 30 days.

LTSS and social services should they become unavailable for any reason and will include emergency contact information. The CPC will ensure the enrollee is aware that all service and support recommendations require EOHHS (or designee) authorization prior to activation, and the request for and response to the request for authorization will be documented as part of the plan.

The plan will also include documentation certifying that the enrollee has: approved and signed the plan; been provided choice around both LTSS providers and programs; been advised that recommended services are subject to MassHealth medical necessity criteria and utilization management requirements; been notified of specific rights, including right to approve the care plan, right to appeal denial, termination, suspension, or reduction in services through MassHealth; the right to request a different CPC from NRLP and the right to request a different LTSS CP; and the right to submit an internal Grievance[6] to the NRLP.

The CPC will shepherd development of a care plan, in concert with the enrollee, to completion (signed by enrollee and approved by his or her PCP and submitted to EOHHS as a "Care Plan Complete" qualifying activity) within 90 days of the enrollee's assignment to NRLP. Upon approval by all required parties, the plan will be provided to the enrollee in the most appropriate and accessible format, reviewed at the enrollee's request at any time, and at least every 12 months and more frequently if there is a major change in the enrollee's status that is not temporary.[7]

a. HOW THE BIDDER WILL ENSURE THE ENROLLEE HAS MEANINGFUL PARTICIPATION…

The NRLP will assign to each enrollee a CPC with the experience and expertise that best addresses the enrollee's situation. Consequently, the CPC will understand how to recognize and provide to the enrollee the supports and accommodations necessary so that he or she can participate as fully as he or she wishes in directing the care plan. The CPC will also administer appropriate assessment tools, submitted and approved for use by EOHHS, designed to identify the community and social services that will optimally support the enrollee's health and well-being. The assessment will also identify appropriate flexible benefits which ACO enrollees may qualify to receive.

Using decision support techniques such as motivational interviewing where appropriate, the CPC will engage the enrollee (or authorized representative) to identify the fundamental framework for the care planning process by clarifying both how the enrollee wants to live his or her life and exploring what may be necessary to make that happen. Serving as coach rather than care manager, the CPC will, when necessary, help strengthen the enrollee's understanding around key elements of the care planning process so the enrollee can better manage it, to the extent he or she wishes, and so that it remains responsive to the fundamental framework. In this way, the enrollee remains at the center of the plan as a whole person with uniquely defined goals that reflect his or her complexities. The plan *does not* define the enrollee primarily in terms of either functional needs or service prescriptions.

However, functional status is among the issues the CPC discusses with the enrollee to support the plan's person-centeredness so that the enrollee understands what this means in terms of daily life as well as service eligibility. Clarifying this promotes the enrollee's ability to drive the plan and to more effectively consider what roles, if any, he or she may wish for family members, friends, and other social supports to play in the care plan, and/or if the enrollee can self-direct his or her care and how that can happen. The CPC will carefully review the range of LTSS services and community resources available to the enrollee (for which he or she is authorized to receive),

[6] The NRLP will develop and submit to EOHHS for approval an internal Grievance Policy outlining protocols and procedures for enrollee as well as staff and stakeholder grievances.

[7] Due to changes in functional limitations, including ADLs and IADLs, natural supports/caregivers, or living situation.

how they address enrollee goals, how they are delivered, how they can be managed, and the degree to which they can be individually tailored to meet specific needs or preferences. Where enrollees are already engaged and receiving services, the CPC will regularly review all of these issues under the direction of the enrollee to identify areas where adjustments may be necessary to support optimal fit between the care plan and the enrollee's needs, preferences, and goals.

b. A DESCRIPTION OF THE BIDDER'S PROTOCOLS FOR PROVIDING INFORMED CHOICE…

Choice is one of the most critical elements of the *Community First* doctrine and as such, providing meaningful choices to enrollees is a principal goal of the NRLP LTSS Coordination model. At its heart, offering choices means providing information about services and resources that is jargon-free, has relevance to who the enrollee is, his or her goals, and what he or she enjoys doing. Providing choices is about supporting the enrollee's access to the "driver wheel" of the care plan, to the extent that he or she wishes to do the driving. Consequently, the NRLP CPC explains the "road map," identifying different LTSS service and community resource options and talking with the enrollee (or authorized representative) about how different LTSS services and community resources work to support consumers and the routines or logistics that may be involved in participating in each one. The CPC will offer at least two providers for each service option. For this reason, the CPC is keenly aware of the LTSS and resource landscape in each community, uses the NRLP centralized inventory and similar sources to ensure the most comprehensive and up-to-date knowledge of what services and supports are available to each enrollee, and follows the enrollee's lead in tailoring a service package that meets the enrollee's needs and best reflects his or her preferences. Ensuring optimal choice also means offering multiple avenues for enrollees to connect with the community in ways that increase sense of belonging and inclusion and that can potentially introduce the enrollee to new and/or desired positive experiences.

The care plan will uniquely represent each enrollee and will shift to appropriately reflect changes in the enrollee's status, needs, and preferences. Including a cohesive overview of the enrollee's strengths and challenges, interests and personal goals, the plan will also address his or her service goals, the choices he or she considered in addressing each of these, as well as the accommodations provided to support enrollee decision-making. The plan will include a section reflecting strategies the enrollee can use to address service-related issues that are not a part of the plan's basic framework as well as back-up arrangements for recommended or ongoing LTSS and social services should they become unavailable for any reason.

Every care plan will identify the LTSS services and programs which the CPC has recommended in concert with the enrollee, including appropriate contact information, and description of how these will be integrated among the various health care, BH, and existing LTSS services which the enrollee may be receiving. The care plan will also include a description of the services and supports that are intended to address identified social determinants of health needs and how these will support the enrollee's improved health, independence and self-determination.

3. CARE TEAM PARTICIPATION

The NRLP CPC will coach the enrollee as the plan unfolds, assisting him or her to navigate through the LTSS service and support networks as appropriate, monitoring plan implementation and ensuring it is fully relevant to the enrollee, monitoring the enrollee's sense of progress as well as tracking changes in the enrollee's context (housing, work, family dynamics, losses, etc.); and working with the enrollee and the Care Team to make adjustments to the plan as appropriate. The CPC will, at the direction of the engaged enrollee, serve as a member of the Care Team and will maintain regular contact with the enrollee that will include a face-to-face meeting at least every three months

(in the enrollee's home or location agreed upon by the enrollee) with consistent telephone connections between meetings, all of which will be fully documented in the enrollee's record.

a. HOW THE BIDDER WILL PROMOTE INTEGRATION OF LTSS COMMUNICATION…

The NRLP CPC will serve as the enrollee's primary advocate, ensuring that the enrollee as a whole person with specific goals and preferences remains at the center of all conversations about him or her and that the choices the enrollee makes are honored as fully as possible. Ensuring that this platform is the basis for all stakeholder activity around the enrollee will facilitate overall coordination, which will involve ongoing communications with area providers, including LTSS, flexible and social service providers as well as primary care providers, and where applicable, MassHealth programs providing case management and Home Care programs to ensure LTSS CP supports supplement but do not duplicate existing supports. Essential documentation will be securely communicated through NRLP's *SyntraNet* capacities on the Mass HIway. The CPC will share appropriate documents with the enrollee in a format that meets his or her language or accessibility needs.

b. HOW THE BIDDER WILL PROVIDE LTSS EXPERTISE AND ADVOCATE FOR APPROPRIATE…

Each NRLP CPC is matched with an assigned/engaged enrollee based on the CPC's experience and expertise working with consumers who have similar disabilities, needs, and social contexts. The CPC therefore begins the journey with the enrollee from a critical vantage point and can more easily discern the enrollee's strengths and challenges and work more effectively with him or her to weave an appropriate service and support plan. As the enrollee's coach, the CPC is also a chief advocate focusing on ensuring that the enrollee's goals remain paramount in all aspects of care delivery. To facilitate this, the CPC will provide ongoing updates – and insights – to the Care Team about the enrollee's experiences and context including social determinant of health issues and how these are being addressed, the impact of LTSS and social service supports on the enrollee's goal achievement, health and well-being, and changes in the enrollee's attitudes, behaviors, and overall status. These updates will be based both on documented personal observations through ongoing contacts with the enrollee, and on the analytics which the *SyntraNet* platform will provide. The CPC will also support the enrollee's role as the primary voice on the Care Team, work to ensure the enrollee understands all communication, and that his or her views have been adequately solicited and appropriately considered.

4. LTSS COORDINATION

The NRLP CPC will maintain ongoing connections with the enrollee, effectively monitoring the enrollee's health, functional, and social status and facilitating communication between the engaged enrollee, ACO/MCO and all relevant LTSS, social service, and community resource providers. As part of the monitoring role, the CPC will also track provider performance according to key service delivery indicators, including: level and nature of staffing; consistency in following care plan; responsiveness to enrollee and other members of Care Team; timeliness of service delivery; quality of logistics (e.g., transportation); enrollee and/or caregiver satisfaction, and more.

a. HOW THE BIDDER WILL MONITOR/MANAGE STATUS/LIFE CYCLE EVENTS…

Because the NRLP CPC is both highly skilled in working with the enrollee population in general and is keenly familiar with the specific context of each enrollee in particular, the CPC can swiftly assess – and even predict – changes which the enrollee may experience. To support the latter capacity, the CPC will utilize the predictive analytics which the *SyntraNet* platform can produce integrating relevant social determinant of health indicators and claims data.

The NRLP CPC will act to alert the Care Team of events that can be counterproductive to the

enrollee's progress and will re-align resources as appropriate to preclude or minimize the impact of such events. For example, the CPC may identify rising tensions within the family context which are negatively affecting the enrollee and offer supports for resolving those. Other examples include issues of grief and loss, medication management, changes in the community and social connections, changes in staffing/service delivery patterns or auxiliary logistics (e.g., transportation), and other developments that can precipitate difficulties for the enrollee which the CPC can proactively address before they escalate.

The CPC works with the enrollee to support his or her progress and therefore will also ensure that opportunities for promoting appropriate growth are optimized. As a coach, the CPC seeks to foster enrollee confidence, sense of competence, sense of belonging, and self-determination. Some life cycle changes, while difficult, are also opportunities. Transition from school to work is one such example, as is transition to a more independent living arrangement. During these times, the CPC will help the enrollee to establish and focus on appropriate daily routines, partialize tasks as necessary, and work to ensure the enrollee feels a sense of accomplishment in making the changes

b. HOW THE BIDDER WILL SUPPORT/ENCOURAGE ENROLLEE'S ONGOING ENGAGEMENT…

The NRLP CPC role is, at its heart, a coaching role. As such, the role emphasizes enrollee engagement as a primary goal, so that the CPC strives to keep choice and control in the hands of the enrollee (or authorized representative) as much as possible, ensuring that the decisions are made by those who know the enrollee best and are most committed to understanding and helping implement the enrollee's goals and preferences. For enrollees who are not able or do not wish to control decision-making, the question is not whether the enrollee can pursue self-determination, but what kind of supports will he or she need to do so and how might caregivers, family, friends, etc. help provide them and promote greater self-advocacy.

At all stages of the care planning process, the CPC seeks to ensure the enrollee (and family) can see him- or herself as a whole person with a multi-dimensional life and opportunities for fulfilling personal goals. Techniques to inspire engagement include motivational interviewing and similar readiness for change approaches wherein the CPC helps the enrollee to explore the ambivalence which he or she (or family members) may hold around making change. The motivation for change belongs to the enrollee. The CPC seeks to clarify what that may entail and encourages the enrollee to use that motivation in the design of the care plan and the choices he or she makes about how the care plan will operate. Motivational interviewing can help the enrollee to remain engaged around the fundamental questions – *how do I want to live my life and what do I need to make that happen?* – and to view the care planning and coordination process as a dynamic means to a very desired end. This is the cornerstone of self-determination, which the CPC supports by helping the enrollee to focus on gains and to consider options for self-directed care.

5. SUPPORT FOR TRANSITIONS IN CARE

The transition in care process is often one of the most perilous for consumers in general, and exponentially more so for those with complex LTSS needs. Consequently, the NRLP LTSS CP will deliver a comprehensive care transitions protocol designed to ensure "safe passage" across care settings. Where transitions are planned, the CPC can provide supports to the enrollee in advance, preparing him or her for the process, clarifying procedures, and ensuring the enrollee knows about and can effectively access appropriate choices around care settings, services, and supports. The CPC can also help ensure that all appropriate staff at all transition points are fully informed about the enrollee's needs and preferences. However, some transitions are not planned or expected and,

in these cases, communications as well as care can become fragmented. Consequently, establishing communications policies with ACOs and MCOs, enrollee PCPs, relevant LTSS providers, and enrollees (and/or authorized representative, caregiver, family, etc.) and the NRLP CPC outlining procedures for notifications that the enrollee is in transition is a high priority.

To facilitate this process, all NRLP LTSS CP enrollees will be provided a "Passport to Health," which serves as the enrollee's advanced directive around health care emergencies and transitions, providing critical health and personal information and identifying important individuals who must be contacted in the event of an emergency. Enrollees keep their Passports with them, often in the accompanying magnetized holder so it adheres to the refrigerator, for example (copies will be on file with the CPC) and are asked to give the Passport to EMTs, ED personnel, or other staff at the transitions points.[8] This facilitates more comprehensive and responsive transition planning, especially when transitions are unplanned. The CPC will contact all appropriate staff related to the enrollee's change in care settings to provide information both about the enrollee as well as the community resources that will strengthen discharge planning and promote more appropriate transition.

a. A DESCRIPTION OF THE BIDDER'S PLAN FOR PROVIDING INFORMED CHOICES…

NRLP staff include trained Care Transitions Intervention™ (CTI) coaches who use motivational listening techniques in conjunction with the Four Pillars of transition established through Dr. Eric Coleman's Care Transitions Intervention™ Coaching method. The CPCs will be trained by the NRLPs certified coaches to implement these procedures:

- Meet the enrollee at the care setting from which he or she is transitioning to discuss the discharge plan, the changes the enrollee has experienced, what the enrollee can expect to happen in the near future and the choices he or she has about this, and concerns which the enrollee and/or family may have about the transition and its aftermath, etc.[9]
- The CPC participates, with the enrollee and/or appropriate designees, in the discharge planning process and helps ensure that all parties focus on the needs and preferences of the enrollee and that the enrollee has as much choice as possible in the care setting to which he or she is transitioning and in the services and supports received there.
- Meet the enrollee at the subsequent care setting (home, SNF, etc.) within 48-72 hours of his or her arrival there to assess the enrollee's status, review the care plan as appropriate, clarify choices available to the enrollee around services and supports, and work to ensure that these are in place. If the enrollee is agreeable, the CPC can begin the Four Pillar review:
  - Help ensure the enrollee has an appropriately scheduled PCP appointment and the logistics are in place to get him or her there comfortably
  - Work with the enrollee and/or designees to reconcile medications
  - Review "red flags" and situations wherein the enrollee should seek emergency help
  - Update the Passport's Personal Health Section and/or other Personal Health Records

[8] NRLP staff have, and will continue to, provide trainings to area EMTs and other medical personnel around the Passport. Several area SNFs have participated in distributing the Passport and the NRLP will expand this number. With over 500 distributed in the initial pilot, the Passports have been helpful for those needing emergency health care, according to preliminary follow-up survey results.

[9] Based on significant experience delivering CTI, the hospital visit is often problematic. NRLP hopes to reduce this barrier as a result of its partnership with the ACO/MCO, which should facilitate access to the enrollee at the appropriate times in the appropriate places.

to include relevant new information. Remind enrollee to take the Passport or other Personal Health Record to all health care visits and make sure the health care provider reviews it.

- Call the enrollee within three business days to assess progress and review care plan. Schedule another visit or phone call as appropriate to review Four Pillars. Schedule a follow-up call for after the PCP visit
- Make follow-up calls as scheduled. Continue weekly calls--and visits as appropriate--until enrollee is stable in new setting.

b. A DESCRIPTION OF STEPS BIDDER WILL TAKE TO ENSURE ENROLLEE'S STABILITY…

The CPC will remain in close contact as the enrollee transitions across care-settings, helping him or her to navigate the changes as effectively as possible by providing critical coaching supports, engaging the enrollee in reviewing and modulating the care plan as appropriate, and keeping him or her focused on moving forward and "sustaining the gains" wherever possible. Because the CPC is a skilled professional with significant expertise in working with populations who have complex LTSS needs in general and with the specific needs of the enrollee in particular, monitoring to ensure stability will include assessing for signs of depression and anxiety as well as other symptoms indicating concern. When these emerge, the CPC will alert the enrollee as appropriate and notify the Care Team. Swift intervention can make an enormous difference in the capacity to sustain transition stability, and the CPC will advocate for the appropriately quick and comprehensive response from the key Care Team members. The CPC will continue an ongoing monitoring.

As part of the transition process, the CPC will re-assess the enrollee relative to needs and preferences around LTSS services and community supports as well as flexible services and discuss how these can be added to or amended in the care plan.

6. HEALTH AND WELLNESS COACHING, INCLUDING BUT NOT LIMITED TO:

a. A DESCRIPTION OF HEALTH AND WELLNESS EDUCATION, COACHING AND HEALTH…

The NRLP offers great expertise around promoting and managing the health and wellness of the target population. Each member entity has an extensive health education capacity that includes highly skilled nurses and social workers who have long experience in delivering health and wellness programming, both as a separate function and as an integral part of overall LTSS direct services delivery. These staff (and curriculum resources) will be available for training and consultation as appropriate to support the CPCs in providing comprehensive education, coaching, and overall health promotion supports.

NRLP CPC will ensure enrollees receive the health and wellness coaching directed by his or her Care Team as specified in the Care Plan, including symptom management, recognition of "red flags" relative to potential negative changes in medical conditions (e.g., what to do when this occurs and when to call for emergency assistance), as well as meaningful and usable knowledge around general disease and injury prevention and chronic disease management. Prevention supports will include working with the enrollee and members of the Care Team as appropriate to reduce high risk behaviors and health risk factors such as inappropriate alcohol or substance use, medication non-compliance, over-eating, poor nutrition, non-compliance with safety measures, lack of exercise, smoking, inadequate sleep patterns, etc. The CPC will work with enrollee to set attainable health and wellness goals and will facilitate the enrollee's access--including resolving logistical barriers such as transportation--to the relevant health promotion activities to support goal attainment. All health and wellness activities, such as those identified below, will be documented in the enrollee's care plan:

- Support to attend specific smoking cessation and weight reduction programs/classes

- Support to attend Kiosk for Living Well sessions at both the permanently sited kiosks around the region and the "roving kiosks" that offer:
  - One-on-one coaching supports as well as a "very fun" interactive virtual technology platform (It's Never 2 Late) that explore health and wellness through a variety of entertaining games, memory exercises, cognitive and therapy programs that promote health engagement and can track progress
  - Health monitoring (by Nurses and CHWs) around hypertension reduction, management of diabetes and COPD and include BP and weight monitoring, individual counseling, group education session, and home visits as appropriate
  - Mobility counseling (by certified practitioners) to prevent falls, including falls risk assessments, balance and coordination exercises, group classes and exercise sessions, travel training, and home safety risk assessments as appropriate
  - Depression screening and mobile mental health counseling supports, as appropriate
  - Memory Cafes, to support both caregivers and care recipients
- Support to attend the Healthy Living Suite of evidence-based Health Self-Management classes available around falls prevention, chronic disease self-management, healthy eating and depression. The CPC will coordinate with the multiple providers of these sessions; maintain a calendar of offerings, and facilitate enrollee's participation in these classes
- Support to attend appropriate health fairs and health offerings, such as yoga
- Support to participate in new Initiatives, such as the Tablet Pilot which features stress and anxiety reduction applications on a large user-friendly tablet with direct communications capacities to mobile mental health staff

7. Connecting Enrollees to Social Services and Community Resources…

a. How the Bidder will evaluate social service needs…

As part of the care planning process, the CPC will complete a social services assessment with the enrollee that will foster a full discussion around the social services and community resources available to him or her and the logistics for successfully accessing these. Currently, the NRLP member entities use a variety of assessment tools as mandated by the various state oversight agencies as well as tools developed to capture additional information on the social determinants of health, including the Risk Assessment and Member Engagement Tools developed for *One Care*. The GLSS-MSO, in concert with subject matter experts from each organization, will consolidate these assessments into a uniform tool-set, following best practice formats such as that recommended by LTQA[10] which stresses clarity of concept and concreteness of measures around at least these key domains:

- Demographics (e.g., age, gender, marital status, language and cultural preferences, household composition) and Family Dynamics (composition, roles, supports)
- Personal interests and meaningful experiences
- Social goals, interests, activities and network (including sense of social inclusion; sense of social competence and confidence, nature of relationships, etc.) and Work-related interests and goals
- Socio-economic status (e.g., income, employment)
- Health status (e.g., health conditions and therapies, self-reported health, vision/hearing, use of medical care, use of prevention strategies, recent health care crises, etc.) and level of

[10] "The Need to Standardized Assessment", LTQA.com, last modified April 29, 2014, http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//LTQA-The-Need-to-Standardize-Assessment-Items-4-14-1.pdf.

interest in maintaining and/or improving health
- Cognition and communication (e.g., memory, speech)
- Medications (e.g., drug regimens, medication use, compliance with medication use)
- Functional status (e.g., ADLs and IADLs, mobility)
- Mental health (e.g., depression, anxiety, sleeplessness, problem behaviors, substance use)
- Nutrition (e.g., diet, height/weight, hydration, food preferences, eating habits)
- Environment (e.g., residential conditions, pets and appropriateness of animal therapy programs)

The screening tool will be coded to integrate with the NRLP Central Resource Database through the *SyntraNet* platform in order to produce the fullest array of resources in the appropriate communities that match assessment results. Based on the conversations that ensue from the assessment, the CPC and enrollee will review the social service and community resources that can be marshalled to meet the assessed needs and expressed preferences. For ACO enrollees, the assessment will identify the flexible services for which he or she is eligible that will best promote his or her health and well-being. The CPC will initiate re-assessments for social services, community resources, and flexible benefits whenever there is a change in the enrollee's status or circumstances. All assessment results and subsequent recommendations will be thoroughly documented as part of the enrollee's care plan. Once authorized, the CPC will assist with navigational supports around accessing services and resources, integrating them as appropriate, and resolving any logistical barriers that may emerge.

b. HOW THE BIDDER INTENDS TO ENSURE ONGOING CONNECTIONS TO COMMUNITY…

To ensure ongoing connections to the community, the CPCs will regularly check-in with enrollees to support sustaining the desired connections and help enrollees problem solve if necessary to remove barriers or disincentives to remaining engaged. For example, in some cases, adjustments in transportation, or in scheduling may be required to meet a changing enrollee circumstance. In others, enrollees may need and want support to navigate through a change in the support resource, such as an unavoidable change in staffing or routine. The CPC will also routinely check-in with the social service or community programs in which the enrollee participates for appropriate feedback on his or her experiences there and to assess whether adjustments can or should be made that would better meet the care plan goals.

D. INNOVATIVE TECHNOLOGIES (*NOT TO EXCEED 1 PAGE*)

The NRLP plans to institute several innovative technological capacities to maximize the impact of its Community Partnership in meeting EOHHS goals. This includes:

- The NRLP will offer a comprehensive communications and database system through *Thrasys/SyntraNet* that is interoperable with internal partners and interfaces with external partners through the Mass HIway. Featuring operational workflow and fiscal management capacities, the system also has important analytical capabilities that include:
  - Integrating claims data with socio-demographic and social determinant indicators to develop risk models that can effectively target interventions and preclude events that undermine health and wellness. This has great potential for reducing both health crises and care costs.
  - Providing ongoing QI measures around NRLP performance relative to quality domains outlined in Appendix C of the RFR, to risk reduction measures, and to the annual QI projects as described in 7.5 I.
  - Providing a centralized database of area-wide LTSS providers, social service providers and other community resources that includes appropriate performance measures.
- The NRLP will explore deploying GLSS' existing mobility management capacities to centralize transportation through its current transportation technology to coordinate trips and vehicles among partner agencies for enrollees in the NRLP CP. The NRLP will also use existing Shore-Tel technologies to operate an after-hours Call Center.
- The NRLP will pilot expansion of a dementia-focused caregiver app developed by GLSS. The App, which uses the smartphone or android mobile phone platforms, focuses on stress reduction, helpful tips, facilitating quick communications, and can be redesigned for a broader caregiver population.
- The NRLP has also been in discussion with SeniorLink around use of its VELA Caregiver Communications app and is proposing a small pilot to determine if the VELA App -- which has had great success in facilitating communications, reducing stress, and optimally supporting caregivers in Adult Family Care programs serving older adults--will work equally well for caregivers of younger populations with potentially more complex LTSS needs.
- The NRLP will also promote the Kiosk for Living Well Tablet pilot which provides a tablet featuring evidence-based depression and anxiety reduction apps to appropriate consumers working with mental health counselors. The Tablet reduces "middle of the night" crises by providing consumers with individually-tailored apps to break escalation cycles. The Tablet offers a "click to request a Counselor call-back in the AM" button and can be configured to connect with emergency personnel at any time.
- The NRLP will leverage the success of the *Kiosk for Living Well* in additional sites across the North Region. Kiosks feature personal health monitoring and education supports, as described in 7.5.C.6, as well as a comprehensive library of *eTools for Health* encompassing short health engagement videos, on a broad range of chronic disease issues, related games, quizzes and activities, tip sheets and so forth which, developed by GLSS, reside on the iN2L virtual technology platforms at each Kiosk under the "GLSS BUTTON" portal on the user screen. *eTools,* moreover, can be transferred to a variety of technology platforms. New programming, reflecting the subject matter expertise of NRLP members, will be developed to meet specific needs of enrollee populations. The NRLP will explore transferring the *eTools for Health* to tablets and smartphones, including the GLSS and VELA Caregiver Apps.

E. Personnel and Staffing (*NOT TO EXCEED 5 PAGES EXCLUDING ATTACHMENTS*)

1. Organizational Chart Attachment that Provides Personnel, Senior Managers …

PLEASE SEE CHART ATTACHED AT END OF SECTION 7.5.E

2. A Sample Staffing Model for the Number of Engaged Enrollees in Each Service Area…

The NRLP LTSS CP has developed a staffing model that reflects these assumptions: 1) the NRLP will: serve 53% of eligible enrollees as described in Table 4 below; 2) maintain an overall ratio of 80% engaged enrollees relative to assigned enrollees; and 3) will, to its fullest capacity, increase the numbers of assigned and engaged enrollees in accordance with EOHHS needs and requests.

The NRLP LTSS CP will operate, at least initially, from well-appointed facilities in three separate locations currently controlled by NRLP members in Beverly, Lynn, and Lowell. However, should the volume of assigned enrollees require additional or different logistics, the NRLP will explore expanding to additional sites held by the members in other areas of the Northern region.

Table 4: Estimated Annualized Enrollees by Service Areas

Region	Service Area	Annualized Members	NRLP Estimated Assigned Enrollees	NRLP Estimated Engaged Enrollees
NORTHERN	Beverly	120	114	91
NORTHERN	Gloucester	133	126	101
NORTHERN	Haverhill	374	94	75
NORTHERN	Lawrence	1,377	551	441
NORTHERN	Lowell	1,062	531	425
NORTHERN	Lynn	528	502	402
NORTHERN	Malden	370	93	74
NORTHERN	Salem	325	309	247
NORTHERN	Woburn	178	45	36
Total		**4,467**	**2,365**	**1,892**

The GLSS-MSO, which will provide the administrative support and operational oversight for the LTSS CP functions, will be located in Lynn and will communicate regularly with staff at other sites as appropriate through scheduled weekly contacts including teleconference, skype, and in-person meetings as appropriate. **Table 5** below provides a brief overview of the proposed GLSS-MSO staffing model.

Through the GNS LINK, the NRLP will lease **LTSS CP Coordinators (CPC)**, **LTSS CPC Supervisors**, as well as **Subject Matter Experts** from its member entities. The NRLP anticipates hiring 20 LTSS CPCs, each of whom will manage a caseload of a maximum of 93 enrollees. The LTSS CPCs will be supervised by 3 LTSS CPC Supervisors, each of whom will carry a caseload of 15 enrollees and will supervise 6-7 LTSS CPCs. Although adjustments will reflect actual volume, the initial plan will site one LTSS CPC Supervisor and a minimum of 5 LTSS CPCs in Beverly, Lynn, and Lowell. The NRLP staff model also assumes 5-7 Subject Matter Experts are identified and available to provide expertise around each population focus group and community contexts as needed, averaging a total of approximately 4 hours per week.

Table 5: GLSS-MSO Staffing Model		
Role	**FTE**	**Brief Role Synopsis**
GLSS-MSO Director	0.1	To supervise overall functioning of the MSO, ensuring that operational strategies optimally meet all NRLP LTSS CP goals and objectives; to serve as primary liaison between MSO and NRLP Executive Committee
Chief Operating Officer	0.15	To coordinate the multiple facets of the MSO operations on a day-to-day basis to ensure effective process and outcome
Director of Care Coordination (Health Care Transformation)	0.1	To provide the clinical management necessary across LTSS CP supports that deliver better health care and health outcomes and lower costs
LTSS CPC Coordinator	1	To serve as overall "ombudsman" in supporting the delivery of consistent and quality LTSS Coordination by facilitating communication, resource flows, technical assistance, training, data gathering and reporting, etc. across sites as appropriate; to oversee the Call Center; to support the Consumer Advisory Board
LTSS CP Trainer	0.13	To work with the LTSS CP Coordinator and the Subject Matter expert in the design and delivery of appropriate training modules
QM Director	0.06	To design and oversee implementation of a comprehensive QA and QI plan; to supervise Analytics and Evaluation Staff
Analytics and Evaluation Staff	1.25	To collect and analyze data to support both QA and QI recommendations; to provide predictive analytics and risk models
Compliance Officer	0.03	To ensure all LTSS CP functions meet EOHHS regulatory and policy requirements
IT Director	0.03	To ensure the seamless functioning of IT systems to their necessary capacities
Fiscal Director	0.03	To ensure quality fiscal management for all aspects of the NRLP LTSS CP
Call Center Staff	1	To support the LTSS CP after-hours I&R/reminder calls; to ensure an up-to-date and accurate Community Resource Database
Admin Support Staff	1.25	To provide the administrative support required to deliver on all functions, including regular reporting
Marketing	0.1	To design and implement appropriate outreach and marketing campaigns/collateral for the LTSS CP

3. A Descriptions of the Bidder's Recruitment Plans…

All proposed positions in the GLSS-MSO are currently filled. NRLP recruitment will focus on LTSS CPCs and LTSS CPC Supervisors. As identified in the **attached job descriptions**, requirements for these positions will meet or exceed those described in the Model Contract. Recruitment efforts will include: postings placed within NRLP member agencies; through GNS LINK partner networks, ACO/MCO partner systems, as well as appropriate regional and statewide coalitions and advocacy groups; at area colleges and universities; and in professional journals as well as local and social media. Postings will be available in fully accessible formats, will clearly delineate job functions and requirements, and include a preference for the bilingual, bicultural capacities that reflect the specific contexts of the communities where the CPCs or Supervisors will work. Numbers and types of staff will be recruited in accordance with projected enrollee volume, which will be carefully calibrated based on information from EOHHS and ACO/MCO partners relative to rates of assigned enrollee referrals.

Table 6. LTSS CPC and Supervisor Recruitment Based on Projected Enrollees

Month	Expected No. of Enrollees	Number of LTSS CPS in Place	Number of LTSS CPC Supervisors in Place	Staff Capacity
1	158	4	1	375
2	315	6	1	555
3	473	6	1	555
4	631	8	2	758
5	788	10	2	940
6	946	12	2	1134
7	1104	14	3	1333
8	1261	16	3	1517
9	1419	18	3	1701
10	1577	19	3	1793
11	1734	20	3	1892
12	1892	20	3	1892

Based on these projections, adjusted to reflect appropriate trends, the NRLP will develop a reasonable "ramp-up" plan that assumes the risk of proactively recruiting, hiring, and training sufficient staff to provide the full range of quality Coordination supports for all expected assigned and engaged enrollees. Table 6 provides a snapshot of current projections and assumes recruitment will begin in January 2018 to begin operations in June 2018 with the targeted number of properly trained staff.

NRLP hiring practices will conform with all contractor employment requirements specified in the Model Contract, including conducting pre-employment CORI checks as well as screening new employees upon hiring and every month thereafter using the US Office of Inspector General's List of Excluded Individuals and Entities relative to participation in federal health care programs. All new hires will be required to participate in a comprehensive training program as described below.

4. A DESCRIPTION OF HOW BIDDER WILL RECRUIT CULTURAL AND LINGUISTIC MINORITIES…

To create a workforce that is fully reflective of the communities which the LTSS CP will serve, the NRLP will establish a multi-level diversity strategy. First, it will convene a Diversity Task Force, comprised of internal staff as well as key external advisors from identified target groups who will: 1) promote extensive diversity networking through local, regional, and statewide cultural associations, community groups, as well as informal connections; professional associations representing diverse groups, and online social media; 2) review and advise on recruiting tools and outreach efforts to ensure resonance with diverse communities; 3) conduct appropriate cultural competence assessments across the NRLP; 4) work with the GLSS-MSO and NRLP member HR Departments to develop and implement resulting recommendations from the assessment to ensure all aspects of the NRLP workplace are appropriately welcoming and supportive to cultural and linguistic minorities; and 5) participate in screening and interviews with the hiring managers as appropriate. Second, the NRLP will work to establish "pipelines" to attract cultural and linguistic minorities by: sustaining and broadening existing relationships with academic and professional groups to develop appropriate internships and externships as well as offer presentations to students or members around opportunities which the NRLP can offer. Third, the NRLP will establish diversity hiring and retention goals, track progress towards those goals, and regularly share these efforts with both internal and external audiences.

5. A Description of How the Bidder will Ensure all Staff Meet competencies…

The NRLP will seek to hire LTSS CP staff who have the experience, expertise, and work ethic to commit to continuously learning, integrating and demonstrating best practices in performance. Towards that end, all new staff will receive comprehensive orientation and training upon hire, annual refresher courses, and additional trainings on new topics as appropriate. Training will include learning modules on:

- Cultural competency
- Disability Awareness
- Accessibility and accommodations
- Independent Living and Recovery Principles
- Motivational Interviewing
- Person-centered planning (for CPCs and Supervisors, using EOHHS-approved curriculum)
- Understanding needs and patterns within the 6 targeted LTSS population groups (for CPCs and Supervisors)
- Principles of Care Transitions (for CPCs and Supervisors)
- MassHealth State Plan LTSS and eligibility criteria (for CPCs and Supervisors, using EOHHS-approved curriculum)
- Health and Wellness principles
- Chronic disease management, red flags, and co-morbidities (for CPCs and Supervisors)
- Using the centralized resource inventory effectively and keeping it dynamic and updated
- Strategies for finding and accessing community resources (for CPCs and Supervisors)
- Mobility Management (for CPCs and Supervisors)
- NRLP mitigation strategies to resolve potential conflicts of interest, including those identified in Section 2.4D of the model contract, which emphasize transparency and disclosure, information and choice, and careful documentation
- Effectively using EHRs and related communication and technology systems, including *SyntraNet*, and its report generation capacities
- Exploring and effectively using outcome and predictive analytics
- Compliance requirements
- Safety requirements and techniques

Learning modules will be presented in multiple formats as appropriate, including in-person group trainings, webinars, and on-line modules. All formats will include opportunities for interaction and feedback as well as assessments to reflect mastery of material. The NRLP will provide training materials to EOHHS as EOHHS prefers and requests and will utilize pre- and post-evaluation as well as other feedback techniques to determine the impact of different modules and different formats relative to achieving learning objectives. The multi-modal learning approach allows for greater flexibility in timing as well as greater capacity to address diverse learning styles. To ensure that the NRLP staff are trained and prepared by the start date, new staff will begin training at least one month prior to full operations launch and will have successfully completed all relevant assessments. After this initial period, NRLP anticipates that CPC staff will complete

necessary pre-employment training within two-weeks prior to independently delivering (or supervising) coordination supports. New CPC staff will shadow existing CPCs during this period as part of their training. Additional and ongoing trainings will be scheduled as appropriate for all staff both as "refreshers" on a regular basis and to introduce new best practice techniques or policy changes as these may emerge.

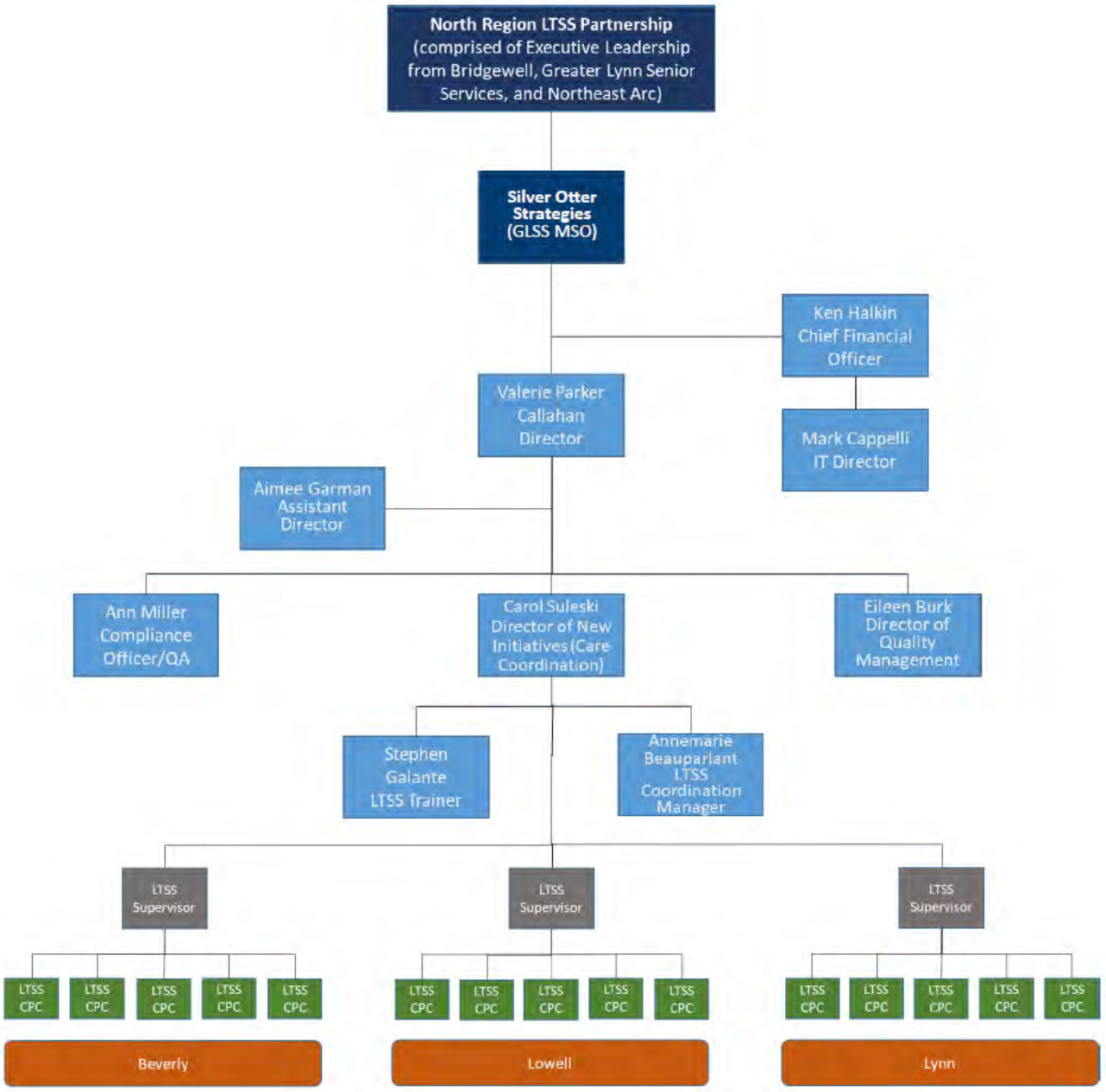
In addition, NRLP staff will participate in the periodic trainings conducted or sponsored by EOHHS that cover various aspects of MassHealth payment reform including Accountable Care Organization and/or Community Partners initiatives, as stated in the Model Contract.

6. A DESCRIPTION OF BIDDER'S STAFF RETENTION STRATEGY

Retention of competent and committed staff is a high NRLP priority. Towards that end, the NRLP seeks to promote a collaborative, supportive and learning-focused environment that encourages and rewards professional growth and performance excellence. To do this, the NRLP focuses on these elements:

- **Clarity of Role:** ensuring that staff understand their role and both its limits and opportunities for innovation. This means correctly identifying the different roles that staff and stakeholders play within the broader context of the NRLP CP and its constituent members, as well as within the context of in the ACO/MCO-BH-LTSS CP partnership and the different communities which the NRLP serves.
- **Appropriate Support:** ensuring that staff are always comfortable asking for assistance or clarification and that they receive clear and meaningful answers. This includes regular check-ins with all staff, eliciting and thoughtfully reviewing feedback and suggestions, and developing a "mentoring" capacity so that staff can connect with "coaches" around specific issues as appropriate.
- **Stress Reduction Activities:** providing NRLP-sponsored activities such as regular yoga, exercise or tai chi classes, periodic "fun" events (e.g. potluck lunches), walking clubs, scavenger hunts, trivia contests, etc. that will engage staff across all NRLP sites
- **Recognizing Achievement:** designing opportunities – based on staff input and preferences – to recognize achievement that "goes above and beyond" on a regular basis which staff find rewarding.
- **Developing a Career Ladder:** developing opportunities within the NRLP for professional growth, including providing or arranging for staff to attend appropriate trainings to build capacities, creating new staff positions as appropriate, etc., and seeking to maintain a competitive pay structure.
- **Emphasize Learning and Best Practice:** emphasize the NRLP's commitment to maintaining a culture of learning and best practice that permeates throughout the Partnership. The NRLP will ensure staff have ample incentive and capacity to pursue regular training opportunities both within the NRLP and through other professional webinars, workshops, and conferences. Staff will be aware of QM and QI findings and encouraged to participate in innovating around improvements.

North Region LTSS Partnership Staffing Model



* Number of LTSS CPCs at each site to vary according to staffing needs/consumer volumes.

F. Implementation Plan and Timeline

PLEASE REFER TO THE REVISED PBP TIME LINE BELOW TO SUPERSEDE THE ORIGINAL ON THE FOLLOWING PAGE

Implementation Tasks	Jan	Feb	Mar	Apr	May
Establish Executive Committee based on GLSS-Affiliated Partner MOU	■				
Hold and properly document monthly Exec Committee Meetings		■	■	■	■
Establish QM Committee, Outreach and Diversity Task Forces with written protocols and clear roles, responsibilities and reporting functions	■	■			
Hold monthly meetings		■	■	■	■
Coordinate HR, Fiscal, etc. Departments across NRLP member entities to design uniform/unified policies and protocols around key NRLP functions	■	■	■	■	■
Develop formal NRLP policies in accordance with Model Contract to include Enrollee Grievance and Rights, Conflict of Interest, Diversity, Compliance, Safety, Etc.	■	■	■	■	■
Design policies, procedures, and systems for coordinating LTSSCs and LTSSC Supervisors across sites and secure approvals to implement		■	■	■	
Install Syntranet and ensure appropriate interface with member communications/data systems	■	■	■	■	■
Develop data sharing support capacities with ACO/MCO partners			■	■	■
Train appropriate staff on new technologies			■	■	■
Design and implement change management campaign to develop uniform LTSS CP culture and approach across different sites and partner entities	■	■	■	■	■
Develop staff orientation and training modules in multiple formats with appropriate assessments; bring in SMEs as appropriate	■	■	■		
Recruit and hire staff (LTSSCs, LTSSC Supervisor, Call Center staff)				■	■
Train both new and existing staff taking on new duties			■	■	■
Conduct outreach to potential ACO/MCO partners	■	■	■	■	■
Develop and finalize MoUs with ACO/MCO partners that clarify roles and procedures	■	■	■		
Explore opportunities to embed NRLP staff at ACO sites as appropriate as part of MOUs				■	■
Initialize Call Center; develop protocols, assign and train Call Center Staff			■	■	■
Build community resource inventories for North Region communities				■	■
Design comprehensive QA/QI plan for NRLP with clear metrics			■	■	■
Design compliance assessment framework			■	■	
Design predictive analytics and reporting framework (using Syntranet)			■	■	■
Design LTSS CP marketing strategies and collateral				■	■
Define, build, activate networks for outreach		■	■	■	■
Prepare facilities in 3 sites for LTSS operations as needed	■	■	■	■	■
Conduct extensive outreach and networking around NRLP throughout service area			■	■	■
Begin development of Consumer Advisory Board, including protocols and member roles, etc.				■	■
Begin plans around launching Kiosks and Mobility Links as part of NRLP				■	■
Provide EOHHS with proof of readiness (as required)	■	■	■	■	■

PLEASE DISREGARD THIS ORIGINAL PBP TIMELINE BELOW AND SEE PRIOR PAGE												
Implementation Tasks	De	Ja	Feb	Mar	Apr	May						
Governance and Administration												
Establish Executive Committee Meeting and Decision-making Protocols												
Hold Monthly Executive Committee Meetings												
Establish NRLP Committees, including Diversity Task Force, Quality Management Committee												
Hold regular (at least monthly) Committee Meetings												
Coordinate HR, Fiscal, etc. Departments across Member entities to create Uniform procedures. Design Workflows												
Develop formal LTSS CP policies in accordance with Model Contract to include Enrollee Grievance and Rights, Conflict of Interest, Diversity, Compliance, Safety, etc.												
Design policies, procedures and systems for coordinating LTSS CPs and Supervisors across sites; secure approvals to implement												
Install SyntraNet and ensure appropriate inter-face with member communication systems and support data sharing with all ACO/MCO partners												
Train appropriate staff on new technologies												
Conduct change management campaign												
Develop staff orientation and training modules in multiple formats with assessments. Bring in SMEs												
Recruit and hire staff												
Train staff												
Conduct outreach to potential ACO/MCO partners												
Develop and finalize MoUs with ACO/MCO partners that clarify roles and procedures												
Initialize Call Center and Protocols; assign Call Center Staff												
Build Community Resource Inventories												
Design QA/QI plan												
Design Compliance Assessment Framework												
Design Predictive Analytics and Reporting Frameworks												
Design LTSS CP marketing strategies and collateral												
Prepare facilities for LTSS CP operations as appropriate												
Conduct extensive outreach and networking around LTSS CP throughout all service areas; Begin CAB development												
Provide EOHHS with proof of readiness												

Budget Period 1												
Implementation Tasks	Jan	Feb	Ma	Apr	Ma	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Accept assigned enrollees												
Conduct Outreach to connect with enrollees; explain program, benefits, rights, options, etc.												
Deliver all LTSS CP coordination supports to assigned enrollees according to principles of person-centered planning and promoting optimal choice; Develop flexible service plans where appropriate												
Acquire authorization for LTSS Service plan												
Provide documentation; utilize data sharing systems, etc. to capture all information appropriately												
Advocate for enrollee as appropriate												
Convene/facilitate CAB meetings and integrate with CP ops												
Conduct regular LTSS CPC supervision with CPCs												
Follow-up with enrollees as appropriate												
Recruit and Hire Additional LTSS CP Staff as needed												
Deliver staff trainings as appropriate												
Provide QA and Analytic Reports												
Assess and adjust workflows as appropriate												
Hold monthly Exec Committee Meetings												
Hold regular QM Committee meetings												
Task Forces and Special Committees meet with Exec Committee at least quarterly												
Provide ongoing presentations about LTSS CP at network meetings throughout region												
Hold NRLP-wide LTSS CPCs and Supervisor meetings w/LTSS Coordinator at least monthly												
Deliver reports to EOHHS as requested												
Conduct Call Center Operations												
Meet with ACO/MCO partners												
Provide risk scores and predictive analytics to ACO/MCO partners and EOHHS using claims data, social determinant of health inventories, and social service assessment data.												
Design and implement effective mobility management strategies as needed and appropriate												
Annually assess and adjust impact of Change Management and Diversity Campaigns												
Implement special annual QI Initiative(s); review findings; make appropriate adjustments												
Conduct all appropriate fiscal management tasks												
Set up additional Kiosk for Living Well Sites and widen potential Tablet pilot to include appropriate enrollees												
Explore expansion of caregiver app and expansion of "eTools for Health" project to other platforms												
Identify impact of predictive analytics on effectiveness of ACO/MCO and LTSS CP interventions												
Prepare an Annual LTSS CP report												

Budget Period 2-5

Quarter	1				2		3					4
Implementation Tasks	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Accept assigned enrollees	■	■	■	■	■	■	■	■	■	■	■	■
Conduct Outreach to connect with enrollees; explain program, benefits, rights, options, etc.	■	■	■	■	■	■	■	■	■	■	■	■
Deliver all LTSS CP coordination supports to assigned enrollees according to principles of person-centered planning and promoting optimal choice; Develop flexible service plans where appropriate	■	■	■	■	■	■	■	■	■	■	■	■
Acquire authorization for LTSS Service plan	■	■	■	■	■	■	■	■	■	■	■	■
Provide documentation; utilize data sharing systems, etc. to capture all information appropriately	■	■	■	■	■	■	■	■	■	■	■	■
Advocate for enrollee as appropriate	■	■	■	■	■	■	■	■	■	■	■	■
Convene and facilitate CAB meetings and connection/integration with LTSS CP operations		■			■			■			■	
Conduct regular LTSS CPC supervision with CPCs	■	■	■	■	■	■	■	■	■	■	■	■
Follow-up with enrollees as appropriate	■	■	■	■	■	■	■	■	■	■	■	■
Recruit and Hire Additional LTSS CP Staff as needed					■							
Deliver refresher annual and new staff trainings as needed					■	■						
Provide QA and Analytic Reports			■			■			■			■
Assess and adjust workflows as appropriate				■			■			■		
Hold monthly Exec Committee Meetings	■	■	■	■	■	■	■	■	■	■	■	■
Hold regular QM Committee meetings	■	■	■	■	■	■	■	■	■	■	■	■
Task Forces and Special Committees meet with Exec Committee at least quarterly		■			■			■			■	
Provide ongoing presentations about LTSS CP at network meetings throughout region			■				■					■
Hold NRLP-wide LTSS CPCs and Supervisor meetings w/LTSS Coordinator at least monthly	■	■	■	■	■	■	■	■	■	■	■	■
Deliver reports to EOHHS as requested			■			■			■			■
Conduct Call Center Operations	■	■	■	■	■	■	■	■	■	■	■	■
Meet with ACO/MCO partners			■			■			■			■
Provide risk scores and predictive analytics to ACO/MCO Partners and EOHHS using claims data, social determinant of health inventories, and social service assessment data.			■			■			■			■
Design and implement effective mobility management strategies as needed and appropriate	■	■	■	■	■	■	■	■	■	■	■	■
Annually assess and adjust impact of Change Management and Diversity Campaigns								■	■			
Implement special annual QI Initiative(s); review findings; make appropriate adjustments										■	■	■
Conduct all appropriate fiscal management tasks	■	■	■	■	■	■	■	■	■	■	■	■
Set up additional Kiosk for Living Well Sites and widen potential Tablet pilot to include appropriate enrollees	■					■						■
Assess impact of new technology projects										■	■	■
Identify impact of predictive analytics on effectiveness of ACO/MCO and LTSS CP interventions						■						■
Prepare Annual LTSS CP Report												■

G. Budget Report and Budget Narrative

Attachment B has been completed in an Excel format and is placed in the document as an attachment in the hard copy and as a separate file attachment in the electronic version.

Please see Attachment C following this page.

H. SUSTAINABILITY (*NOT TO EXCEED 2 PAGES*)

The NRLP's DSRIP investment plan is designed to ensure that our Community Partnership develops the structure and capacity to realize and fully sustain the transformational mission required to deliver *Community First* supports to populations with complex LTSS needs in ways that promote the principles of the MassHealth reform. The NRLP intends to substantively improve health outcomes while reducing health care costs of its consumers, while also promoting community livability and inclusion for all. In this way, we anticipate the NRLP can become a national model, ultimately attracting diverse payors, delivering technical assistance and training around the NRLP model and the innovations that support it. Therefore, by the end of the 5-year Demonstration Program, the NRLP expects DSRIP investment in the key elements described below will continue to maximize impact well beyond the contract term:

***The CPC Model and Training Institute*:** The NRLP is creating a unique CPC model, integrating subject matter expertise from the long-term experiences of its members into a highly skilled, flexible and responsive coaching/coordinator role with strengthened capacities to: deliver person-centered and person-driven supports to a diverse population with complex LTSS needs; communicate clearly and effectively across multiple social, community, and health care sectors and develop sustained collaborations; assess and appropriately marshal LTSS resources according to both clearly documented performance standards and principles of conflict-free case management; effectively manage databases and support data-driven discovery around best practices, and ensure the *Community First* and *Independent Living* paradigms remain the governing precepts in the delivery of health and community supports.

Embedded CPC Liaison. To strengthen critical clinical-community linkages, the NRLP will seek to embed selected CPCs for a portion of their time each week at relevant ACO clinical sites to facilitate referrals, communication flow, and greater care integration in general. Embedding ensures the CPC Liaison becomes a natural and meaningful member of the Care team who, by virtue of sustained interactions, becomes more aware of clinical processes, has more opportunity to provide important perspective and information, and can then better coordinate the community connections for enrollees.

The SyntraNet Platform. The NRLP will implement the *Thrasys/SyntraNet* communications and database platform that will effectively interface with the database systems of each NRLP partner and create a single, unified LTSS CP EHR, effectively connect with ACO/MCO partners and EOHHS; offer an expansive case management software capacity with integrated communications across multiple sites; provide comprehensive analyses incorporating disparate databases; develop predictive analytics based on claims data, assessment data, and social determinants of health data that can significantly strengthen clinical-community linkages, target resources more effectively, and lower health care costs; and create user-friendly area-wide resource inventories.

Community Resource Inventory. The NRLP will design and develop a community resource inventory powered by *SyntraNet,* that captures critical information about LTSS, social service, and other community providers that will be indexed by resource type, location, eligibility criteria, performance ratings (including consumer feedback and NRLP interaction experiences), auxiliary supports provided (e.g., transportation), etc. The Inventory for the Northern Region will be completed in stages and will be updated on a regular basis as a dynamic, interactive tool with at least annual reviews to ensure information is current. Used by all CPC staff, the Inventory will be updated by the NRLP's Call Center operators.

NRLP CP Call Center. The NRLP intends to create an after-hours Call Center capacity to

provide basic information and referral about the LTSS CP, triage inquiries as applicable including to designated on-call NRLP CP staff, connect with enrollees as appropriate to provide reminders around appointments, ensure logistics are in order (and other check-ins), and work on developing the Community Resource Inventory. An after-hours capacity using GLSS existing *Shoretel* call center technology will facilitate better communications with enrollees and their caregivers who may wish support after the LTSS CP is officially closed for the day. Call Center operators will not be clinicians, but will be trained to recognize when callers need immediate assistance and to follow clear protocols connecting them with appropriate supports in those instances. In all other cases where basic NRLP CP information is not sufficient, the Call Center will forward messages to the CPCs who will return the call at the start of the next business day.

Mobility Management. The NRLP will seek to integrate its current Transportation Call Center capacities within the NRLP to better coordinate member transportation programs and vehicles to create efficiencies. The NRLP plans to offer mobility counseling to enrollees (available at the Kiosk for Living Well sites and by appointment elsewhere) which includes falls risk assessments, falls prevention, balance and coordination exercises, home safety assessments, travel training, and trip planning.

E*xpansion of the Kiosk for Living Well.* The NRLP will seek to leverage the powerful capacity of the Kiosks for Living Well by expanding its locations and programming to support a broader population with more complex LTSS needs. A particular focus will be development of additional applications for the iN2L virtual platform that address the needs of younger consumers living with a wider range of disabilities. While this capacity will initially be available through the iN2L stations, it will ultimately be transferrable to tablets and potentially smartphones, etc.

Expansion of the Kiosk for Living Well Tablet Pilot. The NRLP will explore expansion of its existing tablet pilot, which offers consumers struggling with anxiety and depression a user-friendly tablet loaded only with evidence-based applications to reduce anxiety and depression symptoms. Designed to support consumers through overnight crises and avoid preventable emergencies during this time, the tablet includes the capacity to connect with appropriate staff as needed.

Caregiver Apps. The NRLP will also explore expanding the GLSS Caregiver smartphone/Android App (*Caregivers Matter by GLSS)*, currently designed for caregivers of care recipients with dementia, to meet the needs of a broader caregiver population. It will also actively explore a partnership with SeniorLink to pilot their VELA caregiver smartphone applications for a targeted group of enrollee caregivers.

Discovery. The NRLP will generate substantive reports on its various innovations, identifying most promising practices, and providing empirical evidence around impact. Based on this effort, we will then seek to partner with professional/academic evaluation teams (as we are currently doing with Boston University for the Kiosks for Living Well) to deliver more in-depth analyses.

I. QUALITY MANAGEMENT (*NOT TO EXCEED 3 PAGES*)

1. A DESCRIPTION OF THE BIDDER'S QUALITY IMPROVEMENT PROGRAM

The NRLP QM framework will fully embrace the three core elements of quality assurance:

Discovery: gathering the data and information that reflects consumer experiences relative to key variables such as choice, self-determination, satisfaction, and health and well-being outcomes. The discovery process helps identify how well programs are working, where they are strong, and where there are opportunities for improvement. Discovery elements include:

- Documentation reviews and ensuring documentation data is appropriately correlated to identify patterns of service need, delivery, outcomes, and consumer satisfaction
- Consumer surveys, focus groups
- Staff/Consumer/Provider Complaint/Compliment log
- Direct observations (staff, supervisors, etc. through journal notes and interviews)
- Integration of multiple data sources to clarify outcome relationships
- Effective capture, organization, and correlation of assessment data, claims data, and relevant health status data

Remediation: developing the correctives to program implementation that addresses barriers to goal achievement and/or to compliance with quality standards. Remediation elements may include:

- Increased supervision and corrective action plans
- Increased training
- Changes in staffing patterns
- Changes in supervision structure
- Changes in staff and/or department routines and responsibilities
- Changes to program processes
- Changes in quality management procedures
- Changes in program implementation or contracting agreements

Continuous Improvement: using and disseminating data and information that is ongoing and continually updated to strengthen both process and outcomes. Information from both Discovery and Remediation phases should be used to create more effective staff routines and stronger consumer outcomes. Key aspects of continuous improvement efforts include:

- Greater focus on quality assurance procedures and their relationships to outcomes
- Sustaining a management culture that encourages continuous improvement through an annual review process
- Staff training to ensure uniform practices, increased competencies and adherence to protocols and procedures
- Participation in regional collaborations around QA issues to identify best practice approaches

The NRLP will use the *SyntraNet* platform (described above) to capture and integrate disparate data sources to measure CP performance. This will include the slate of Quality Measures outlined in Appendix C[11], will also include the constituent indicators that will identify NRLP progress in the key areas of Prevention and Wellness, Member Experience, Integration, Avoidable Utilization and

[11] NRLP will provide EOHHS with data for each quality measure as requested, including medical data as appropriate, and in the form and format requested by EOHHS.

Engagement. Consequently, QI efforts will include a focus on improving the rates with which enrollees make wellness and annual primary and dental care visits, are appropriately screened for social services and use of flexible services, experience a reduction in all-cause 30 day readmissions and preventable ER visits, have a documented and approved care plan within 90 days of assignment to the NRLP and complete the care plan. QI efforts will also focus on improving member experience working with the NRLP LTSS CP relative to service delivery, health and wellness, choice, and quality of care, based on information received from the EOHHS. As part of its annual update process and with approval from EOHHS, the NRLP will also ask enrollees for feedback on these elements.

SyntraNet will also allow the NRLP to develop predictive analytics based on claims data and appropriate social determinant of health (SDOH) data gleaned through the NRLP's social services screening tool set. To ensure that SDOH data is most meaningful, the NRLP Quality Task Force will work with its ACO partners to clarify meanings and establish clear definitions for SDOH indicators. The ensuing predictive analytics will allow the NRLP CPs to provide critical information to the Care Team about specific enrollee risks including the likelihood of preventable events and the strategies that can best prevent them, including targeting interventions and resources more precisely. The data will also help the NRLP focus on harnessing its capacities to reduce risk areas and measure the effectiveness therein over time.

2. A Description of at least one Quality Initiative the Bidder Proposes to Undertake…

The GLSS-MSO QM Director will ensure the delivery of an annual QA report for approval by the Quality Management and Executive Committees and submitted to EOHHS. The plan will include QI initiatives around one or more of the following each year: consumer quality of life, chronic disease management, caregiver stress, community tenure, isolation and social connectedness, care coordination and care transitions. In its first year, the NRLP will conduct a quality improvement initiative designed to reduce caregiver stress as measured by changes in these indicators:

- caregiver's self-reported levels of stress
- caregiver's self-reported levels of health and wellness
- caregiver's assessment of the quality of interactions with care recipient
- caregiver's assessment of the quality of interactions with NRLP CP and LTSS providers
- caregiver's assessment of care recipient's life quality, well-being, engagement
- caregiver's degree of social interactions and sense of belonging/inclusion in the community
- caregiver's assessment of his/her navigational capacity around identifying and securing resources
- caregiver's willingness and ability to follow and complete a care plan
- caregiver's overall assessment of confidence, competence, and support around caregiving

Data will be gathered at time of enrollment and 9-10 months after participation in NRLP has begun. As part of the "post-intervention" survey and/or interview, caregivers will be asked to rate the impact of the following on their stress level assessments:

- The overall impact of the care plan
- The level of ease in implementing the care plan
- The level and impact of the Coordinator's knowledge and skills in responding to questions, issues, etc. and the timeliness of the response
- Use and assessment of the "after-hours" Call Center for information and faster response
- The degree of ease of access to the Coordinator and timeliness of responses, etc.

- The impact of an After-Hours Call Center on making connections and relieving stress
- The impact of the technology connections offered them (where relevant)– through the Kiosks for Living Well/Memory Cafes, Tablet, or Caregiver Apps[12]
- The impact of caregiving support groups (where relevant)

To facilitate overall quality improvement, the NRLP will also institute and design appropriate assessments of the impact of these programmatic initiatives during Year One:

- Implementation of consolidated electronic health record database that accurately, completely and efficiently captures relevant information from NRLP members and supports robust reporting of critical and clearly defined quality outcomes indicators that address quality of life, chronic disease management, caregiver stress, community tenure, social connectedness, care coordination and care transitions as well as the specific slate of measures identified in Appendix C of the RFR.
- Integration of methodologies for collecting data and reporting on results to provide consistent and accurate reporting from the entire NRLP, ensuring a focus on the impact of care coordination.
- Developing meaningful and measurable targets for key indicators related to health and wellness in concert with ACO/MCO partners (quality of life, social connectedness, social determinants of heath) and institute methodologies to achieve targets.

3. The Functions of the Bidder's Quality Management Committee

The Executive Committee will authorize a Quality Management (QM) Committee comprised of appropriate senior level professionals from each member organization who will work closely with the GLSS-MSO QM Director and QM staff. The Executive Committee will maintain oversight of QM operations through at least quarterly meetings with the QM Committee (which will include the MSO-QM Director) and QM reports will be included at all regular Executive Committee meetings. The QM Committee will meet at least monthly to review the status of each QM initiative; track progress against key indicator targets; discuss causes, trends and patterns which the data collected demonstrate, and identify quality concerns as they arise. These discussions may prompt the development of an ad-hoc committee to address any issues as needed. Action items will be addressed by the appropriate operations staff and closely monitored by the QM team who will provide updates about such action items at subsequent QM and Executive Committee meetings. The Executive Committee will receive a thorough annual review of all QM/QI initiatives from the QM Director, as approved by the QM Committee.

[12] Dissemination of technology options will be preceded by appropriate PDSA cycles and subsequent carefully constructed pilots.

J. COORDINATION WITH ACOS AND MCOS (*NOT TO EXCEED 2 PAGES*)

1. HOW BIDDER WILL COMMUNICATE BIDDER'S SKILLS, EXPERTISE, VALUE TO POTENTIAL ACOS/MCOS

The NRLP intends to communicate its skills, expertise, and value to potential ACOs/MCOs through multiple mechanisms that include: initial face-to-face meetings with appropriate staff to introduce the NRLP, its strengths and experience, its capacity to effectively manage community connections in support of the MassHealth reform mission, and its capability to deliver critical and predictive analytics that will ultimately reduce ACO costs and improve health care quality and health outcomes. The NRLP will discuss its experience in strengthening clinical-community linkages and facilitating patient access to care, finding at-risk patients and supporting appropriate connections to primary care, providing effective health monitoring and follow-ups for vulnerable patients and communicating appropriate information to clinical staff. The initial discussion will also include an overview of experience with LTSS Coordination, including *One Care*, and the ongoing outcomes evidence collected demonstrating the value of the proposed NRLP LTSS Coordination model. In this discussion, NRLP members will identify the scope of their presence and impact across the Northern region and provide examples of the unique assets they offer and how these can be tailored to meet specific ACO/MCO needs. The proposed technology innovations, as discussed in 7.5D, will be presented. The NRLP will leave the ACO/MCO representatives with brief written materials summarizing portions of the discussion as well as links to relevant NRLP organization and/or project websites and videos.

After the initial introductory discussion, the NRLP will invite ACO/MCO staff to more formal presentations, site visits or other demonstrations around the programs and projects of particular interest to them and will provide additional reports and materials as requested. NRLP staff will follow-up with the ACO/MCO participants to solicit feedback and, if not already in place, generate a collaborative agenda on moving forward with a Memorandum of Understanding (MOU).

2. THE BIDDER'S BRANDING AND MARKETING PLAN W RESPECT TO ITS RELATIONSHIPS W ACOS/MCOS

The NRLP will launch a multi-faceted marketing campaign to promote strong relationships with ACOs/MCOs that will include:

- Building on existing relationships -- that include initial partner conversations around improving health care and health outcomes while reducing costs -- which the NRLP has developed with potential ACO/MCO entities in the Northern Region
- Establishing uniform and concise NRLP collateral materials with consistent messaging in multiple formats including conventional brochures as well as web sites and social media
- Developing a short presentation brief and video (accessible on-line) that emphasizes the NRLP brand
- Inviting ACO/MCO representatives to relevant meetings through the LINK partnership where the short presentation brief is delivered and where attendees may receive collateral such as an NRLP mug, etc.
- Attending appropriate conferences and tradeshows to connect with ACO/MCO staff and share NRLP collateral materials
- Writing appropriate articles and/or briefs in conjunction with existing academic partners that are germane to ACO/MCOs relative to LTSS CP

- Securing and leveraging appropriate endorsements from health care providers for whom collaborating with NRLP members has made a significant positive difference

3. The Bidder's Strategy to Engage/Collaborate w Multiple ACOs and MCOs in Service Areas

The NRLP will approach all ACOs/MCOs in consistent fashion, following the general outline described above. However, the NRLP will strive to tailor its approach to meet the specific needs and preferences of each potential ACO/MCO partner in the Northern MCO region. The NRLP will be transparent with each ACO/MCO about its potential for and interest in multiple partnerships but will maintain full confidentiality around specific negotiations and proposed collaboration details with each.

The NRLP will offer each ACO/MCO the opportunity to participate in the NRLP training program by: 1) contributing subject matter expertise around a particular learning module; and/or 2) identifying ACO/MCO staff to participate in select learning modules, either in person or through on-line access and webinars. This process will facilitate greater inter-organizational awareness and, once launched with one ACO/MCO, can leverage greater participation by additional ACO/MCOs who do not wish their "competitors" to be the single clinical partners in the effort. Promoting area-wide learning collaboratives in this way is an important strategy for creating stronger connections and less dissonance in protocols and procedures across service regions.

4. The Bidder's Strategy for Conflict Resolution, Should Any Conflicts Arise Between Bidder and…

The NRLP strategy for conflict resolution is grounded in the basic tenets of effective partnerships, which includes:

- Establishing and maintaining clear communications and ongoing capacities to identify issues before they become conflicts. This can include scheduling regular meetings of key program staff as well as decision makers to review ongoing efforts.
- Clarifying expectations and roles from the outset of the partnership and capturing this in a clearly developed MOU, with options for revisions and amendments as needed, appropriate, and approved by EOHHS.
- Sharing substantive experiences on a regular basis, such as presentations on innovations, findings, unusual issues, etc. relative to the enrollees and their care. These presentations should further clarify and inform the shared data and potentially open the door to further collaborations.
- Developing mutually agreed-upon protocols for resolving differences that include notifying appropriate staff contacts about issues, the preferred form of contact and the parameters for response time, procedures for resolution including documentation of the process, which may include revision of the MOU.

K. Providing Culturally Competent, Informed Service Supports (*not to exceed 2 pages*)

1. Describe how the Bidder will Provide Effective, Equitable, Understandable and Respectful

a. How the Bidder will provide language/communication assistance

The NRLP fully embraces diversity as a core value of organizational culture and places high priority on its strategic initiative to continually increase access to isolated, low income and culturally diverse communities. NLRP members actively recruit employees who reflect the diversity of the communities and consumers served, maintaining multi-lingual staff throughout each organization and providing linguistic translation for 16 languages including ASL, Cantonese, Creole, French, Italian, Khmer, Portuguese, Russian and Spanish. The NRLP can also access GLSS' contract with a secure, qualified interpreter (International Medical Interpreters of the North Shore) for both medical and non-medical purposes. To accommodate specific linguistic needs of each consumer beyond this capacity, the NRLP staff can utilize the AT&T Language Line for callers with limited English proficiency providing translation for virtually all languages spoken in the Commonwealth as well as TTY telephony machines to communicate with consumers with hearing and speech impediments. NRLP staff can access the Mass Relay Operator who transcribes conversations for consumers with hearing impediments. The NRLP will also revamp its websites and electronic forms with accessibility in mind by employing universal design principles and WCAG 2.0 guidelines. WCAG guidelines require that we keep the layout simple and easy to use for people with cognitive disabilities.

b. How the Bidder will inform Enrollees of available language and…

The NRLP will ensure that enrollees are aware of the language and communication assistance available to them and that the preferred language is noted in the Care Plan and made available to all relevant staff. Notices of Availability of Free Language Assistance Services will be posted on websites, included in all marketing materials and correspondence, posted at key cultural sites in the various communities served, and included with the Care Plan document itself. The CPC will ask if such assistance is preferred at the earliest encounter with the enrollee and document both the response and, where desired, the resources utilized to provide the assistance.

c. How the Bidder will provide supports in a manner response to cultural…

The NRLP CPCs will be trained to respectfully engage enrollees in simple, non-judgmental conversations about their health beliefs, customs, and experiences, gently but clearly inquiring about whether and how cultural values – e.g., restrictions around clothing, exercise, personal interactions and personal space – play a role in their daily lives. Asking the enrollee, for example, what the CPC should know about his or her religious or cultural beliefs that will help to develop a better care plan also helps the enrollee to maintain control of the care planning process. The CPC will use this information to help identify the LTSS and community services with which the enrollee will be most comfortable.

Through conversations with the enrollee, the CPC will identify his or her overall health literacy and will provide information and supports in a manner that avoids challenging enrollee assumptions but that also offer meaningful learning opportunities. As part of the ongoing health and wellness coaching element of the CPC role, these opportunities will be documented in the care plan and will include one-on-one counseling as well as appropriate health promotion activities as described above.

2. DESCRIBE THE EXPERTISE AND EXPERIENCE THE BIDDER HAS PROVIDING CARE TO SPECIAL POPULATIONS…

a. HOMELESS: Bridgewell provides safe and affordable housing in Lowell and Lynn for individuals with disabilities, the homeless and individuals with dual diagnosis. Housing opportunities range from rooming houses to apartment living, many including rental subsidy programs funded by HUD. GLSS supports a homeless elders program helping to relocate displaced elders or elders at-risk of homelessness, prevent evictions, resolve landlord-tenant disputes and other barriers to tenancy, access benefits to augment income, complete and file housing applications and prepare associated documentation. GLSS also sponsors a weekday breakfast for homeless and other seniors, providing them with an opportunity to informally meet with the housing advocate and nurses. NeArc focuses on finding housing for those who are medically fragile, deaf and hard of hearing and/or living with autism spectrum disorders.

b. LGBTQIA: GLSS added a part-time LGBTQIA Coordinator in July 2016 to develop and coordinate LGBTQIA-inclusive aging services, programs, and outreach. GLSS provides LGBTQIA cultural competency presentations to staff, volunteers, providers, and community partners. Bridgewell offers individuals in residential services the opportunity to participate in an LGBTQIA program run by DDS. NeArc and Bridgewell integrate LGBTQIA supports within their services.

c. CRIMINAL JUSTICE: Many individuals in NLRP programs are involved with the criminal justice system and NRLP staff provide them with support and guidance as they navigate the criminal justice system. NRLP members have developed a very strong connection with local law enforcement agencies, the Essex District Attorney's Office, and the Essex County Sheriff's Department. With the Essex County DA's Office, Bridgewell runs a Diversion Program for first time offenders. GLSS sponsors: Protective Services, Women's and Family Abuse (formerly known as Older Battered Women's) Program; and Elder Law Project to address a variety of concerns such as benefits issues, housing matters and elder abuse cases.

d. LIVING WITH VISION OR HEARING CHALLENGES: As noted earlier, each NLRP member actively accommodates those individuals who are blind, low vision, deaf or hard of hearing throughout the service system, through enhancements made to the agency websites and tools offered to individuals (such as the Kiosks for Living Well adaptive programs), use of the TTY and Mass Relay Operator, and by a sensitive care plan crafted by and for the individual. GLSS also offers training to community agencies on 508 compliance and pre-audit preparation.

e. COGNITIVE DISABILITIES: NRLP staff work with individuals living with cognitive disabilities every day, (autism spectrum, intellectual or developmental disabilities, traumatic brain injuries, progressive dementia, Alzheimer's, or mental health disorders). Besides the day-to-day interaction, NRLP staff actively promote additional programs such as caregiver and community education on creating dementia-friendly communities; and delivery of the Disability Awareness Training now available to professionals and community.

NRLP members have long served people from different cultures,[13] locating key programs in areas rich in diversity, building a culturally competent staff capacity, and ensuring that facilities, equipment, and communications meet all appropriate ADA 508 and 504 compliance requirements.

[13] Further examples: Bridgewell opened a Cultural/ Linguistic/ Autism Specific Family Support Center in Lynn in 2016 providing a culturally and linguistically diverse Family Support Center for Cambodian and Latino families living in Lynn and surrounding areas who have children and adults living at home who are on the Autism spectrum. GLSS actively promotes its Latino Outreach program drawing hundreds of visitors each year for assistance with housing, public benefits and translation support.

ATTACHMENT A: JOB DESCRIPTIONS

ATTACHMENT B: BUDGET REPORT

Community Partner Program Budget Report

Innovative Care Partners, LLC

Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Estimated Enrollees- Start of Period (All Enrollees)		400	1,200	1,800	2,700	2,700	
Estimated Enrollees - End of Period (All Enrollees)		1,200	1,800	2,700	2,700	2,700	
Estimated Enrollees - Monthly Average		900	1,675	2,490	2,700	2,700	
Total Estimated Program Revenue		**$ 504,000**	**$ 1,608,000**	**$ 2,390,400**	**$ 2,592,000**	**$ 2,592,000**	**$ 9,686,400**
At- Risk Withhold Rate			0%	0%	10%	10%	
Withhold funds			$ -	$ -	$ 259,200	$ 259,200	$ 518,400
Revenue for Operations		$ 504,000	$ 1,608,000	$ 2,390,400	$ 2,332,800	$ 2,332,800	$ 9,168,000

Program Expenses		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Salary		$ 89,167	$ 454,167	$ 1,047,271	$ 1,478,543	$ 1,581,525	$ 1,568,626	$ 6,219,299.00
Fringe		$ 21,656	$ 106,205	$ 289,933	$ 411,651	$ 440,352	$ 432,109	$ 1,701,906.00
Total Personnel Costs		$ 110,823	$ 560,372	$ 1,337,204	$ 1,890,194	$ 2,021,877	$ 2,000,735	$ 7,921,205
Training & Professional Development		$ -		$ -	$ -		$ -	$ -
Travel		$ -	$ 27,048	$ 90,300	$ 132,678	$ 133,224	$ 133,224	$ 516,474
Equipment			$ -	$ -	$ -	$ -	$ -	$ -
Supplies		$ 5,500	$ 54,000	$ 41,000	$ 36,000	$ 36,000	$ 36,000	$ 208,500
Contract Services (consulting, professional)		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Software licensing		$ -	$ 18,900	$ 60,300	$ 89,640	$ 97,200	$ 97,200	$ 363,240
Telecommunications		$ 4,680	$ 31,500	$ 63,600	$ 63,600	$ 63,600	$ 63,600	$ 290,580
Occupancy (rent, utilities, maintenance)		$ 13,500	$ -	$ -	$ -	$ -	$ -	$ 13,500
Other		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Direct Costs		$ 134,503	$ 691,820	$ 1,592,404	$ 2,212,112	$ 2,351,901	$ 2,330,759	$ 9,313,499
Indirect Cost/Administrative Overhead	**11.0%**	**$ 14,795**	**$ 76,100**	**$ 175,164**	**$ 243,332**	**$ 258,709**	**$ 256,383**	$ 1,024,485
TOTAL EXPENSES		$ 149,298	$ 767,920	$ 1,767,568	$ 2,455,444	$ 2,610,610	$ 2,587,142	$ 10,337,984
Surplus/Shortfall		*$ (149,298)*	*$ (263,920)*	*$ (159,568)*	*$ (65,044)*	*$ (277,810)*	*$ (254,342)*	*$ (1,169,984)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
CP Director	$ 140,000.00	0.4	5	$ 23,333
Care Coordinator Supervisor	$ 52,000.00	3	1	$ 13,000
Care Coordinator	$ 38,000.00	6	1	$ 19,000
Enrollment Manager	$ 60,000.00	0.4	4	$ 8,000
Enrollment Specialist	$ 34,000.00	1	1	$ 2,833
Administrative Assistant	$ 30,000.00	0.6	6	$ 9,000
Trainer	$ 70,000.00	0.4	6	$ 14,000
				$ -
				$ -
Total Salary (Program Budget Line 1)		**11.8**		**$ 89,167**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 89,166.67	24%	$ 21,656
Total Fringe (Program Budget Line 2)			$ 21,656

Total Personnel*	**$ 110,822**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

The Director provides overall management of BH CP program;
-Care Coordinator Supervisor supervises Care Coordinators assigned to CC Team; review and sign off on comprehensive assessments;
-Care Coordinators advocate and coach enrollees to achieve treatment goals, linking enrollees with resources; documentation of member encounters in medical records
-Enrollment Manager designs enrollment plan, manages department, supervises Enrollment Specialists, conducts outreach; provides liaison function with ACOs and MCOs.
-Enrollment Specialist conducts enrollee intake, including outreach to Assigned Enrollees, and assigns enrollees to appropriate Service hub.
-Administrative Assistant provides administrative support to Program Director and is responsible for compiling and updating Community Resources Directory.
- Trainer is responsible for assessing the training needs of the Community Partners staff and developing training curriculum to meet those needs. Plans in-person and online training; oversees training records;

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost

Total Training and Professional Development (Program Budget Line 3)	

Provide a description of each Training and Professional Development line item included in the table above:

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
			Total Mileage	

Travel Expense Description	Cost
Total Mileage	$ -
Parking and tolls	
Public transportation	

Enrollee travel	
Total Travel (Program Budget Line 4)	**$ -**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

Row 5 - Equipment

Description of Equipment	Unit Cost	#units or FTEs	Cost
Total Equipment (Program Budget Line 5)			

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Postage & office supplies			$ 5,500
Total Supplies (Program Budget Line 6)			**$ 5,500**

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Routine general office materials to be used in normal course of administration. Estimate is pursuant to provider experience and assumed adequate levels for anticipated prep period staff.

During prep period, there will be approximately 12 FTEs. It is expected that over the course of the 7 months, office supplies will account for $1,500 or $125 per FTE. The remainder of the estimate ($4,000) is for postage. It is expected that a significant amount of material will me mailed to numerous constituents and others regarding the development of the program, recruitment for the program, etc.

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost

			Total Software Licensing (Program Budget Line 8)	

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Land lines for 3 sites for 3 months; assume $300 per month/per site, apportioned as 60% for BH CP; remaining 40% is LTSS CP	300	3	$ 1,080.00
Internet data lines for 3 months for 3 sites; assumed $400 cost per site using current experience;	400	3	$ 3,600.00

Total Telecommunications (Program Budget Line 9)	**$ 4,680.00**

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Land lines will support desk-top activity for communication with clients and other constituents, complimenting availability of cellular communication. Internet data lines are essential for routine communication as well as for web-based access to EHR software.

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
Rent	9000	15	$ 13,500.00
Utilities			$ -
Repair and Maintenance			$ -
			$ -
			$ -
Total Occupancy (Program Budget Line 10)			**$ 13,500.00**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

Provider will require 3 regional offices in service areas at 3K square feet each for ultimate staffing levels. Rent would begin 3 months prior to 6/1 start of services to support hiring, staffing, training and general program start-up. Rental rate is presumed at $15 inclusive of utilities, housekeeping and common area management. No repairs and maintenance are expected in prep period (general CAM is included in $15/psf rate). Note: costs are allocated 60% to

maintenance are expected in prep period (general O&M is included in $25/psf rate). Note: costs are allocated 60% to BH CP and 40% to LTSS CP in prep period only. Thereafter, BH CP absorbs full space for common use with LTSS CP, given financial inability for LTSS funds to share in allocation.

At maximum staffing levels, 140 individuals between LTSS and BH will be employed, office space for which will be provided in regional locations. While all staff are not expeccted to be at each office 100% of their time and many staff can share space (rather than dedicated cubicle/office per person), 9,000 sq feet is based on general allocation of approximately 60 sq feet per work station/area, plus common space such as conference rooms.

Row 11 - Other

Other Direct Expense Description	Cost
Total Other Direct Costs (Program Budget Line 11)	

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead	**11.00%**	**$ 14,795.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Administrative overhead required to effectively execute and coordinate the business functions of the community partner services is inclusive of following support services:
A) Finance administration
B) HR management
C) Qualitative performance measurement & reporting
D) Tax and cost report compliance
E) Third party billing and contract management
The 11% rate reflects historical experience of Innovative Care Partner's managing partner (CHD). CHD's current federal allowable indirect rate is 11.7%.

Community Partner Infrastructure Budget Report

		Innovative Care Partners, LLC						
Infrastructure Investment Funding		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
PMPM Infrastructure Rate			$ 75.00	$ 49.72	$ 43.28	$ 36.40	$ 29.34	
Engaged Enrollees			1,200	1,200	1,800	2,700	2,700	
Estimated Infrastructure Funds			$ 630,000	$ 715,929	$ 934,872	$ 1,179,276	$ 950,658	**$ 4,410,735**
At- Risk Withhold Rate				25%	44%	63%	81%	
Withhold				$ 176,804	$ 407,871	$ 737,771	$ 774,730	**$ 2,097,176**
TOTAL MAXIMUM FUNDS AVAILABLE		$ 450,000	$ 630,000	$ 539,124	$ 527,001	$ 441,505	$ 175,928	**$ 2,763,559**
Infrastructure Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ 124,000	$ -	$ -	$ -	$ -	$ -	**$ 124,000**
Technology for Service Delivery		$ 33,000	$ 45,000	$ -	$ -	$ -	$ -	**$ 78,000**
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Total Technology		$ 157,000	$ 45,000	$ -	$ -	$ -	$ -	**$ 202,000**
Workforce Development								
Workforce Development staffing including Fringe		$ 14,900	$ 17,273	$ 30,425	$ 30,425	$ 30,425	$ 30,425	**$ 153,873**
Recruitment Expenses		$ 20,000	$ 20,000	$ 20,000	$ 16,000	$ 15,000	$ 5,000	**$ 96,000**
Training Expenses		$ -	$ 30,000	$ 24,000	$ 24,000	$ 34,000	$ 12,000	**$ 124,000**
Retention Expenses		$ -	$ -	$ -	$ -	$ 10,000	$ 5,000	**$ 15,000**
Total Workforce Development		$ 34,900	$ 67,273	$ 74,425	$ 70,425	$ 89,425	$ 52,425	**$ 388,873**
Business Start Up Costs								
Office Equipment (PBP & BP1 only)		$ -	$ -					**$ -**
Office Furniture (PBP & BP1 only)		$ 40,000	$ -					**$ 40,000**
Ramp-up Costs (PBP BP1, BP2 and BP3 only)		$ 149,298	$ 263,920	$ 159,568	$ 65,044			**$ 637,831**
Total Business Start Up Costs		$ 189,298	$ 263,920	$ 159,568	$ 65,044	$ -	$ -	**$ 677,831**
Operational Infrastructure								
Operation Staffing including Fringe		$ 29,000	$ 50,378	$ 88,739	$ 88,739	$ 88,739	$ 88,739	**$ 434,334**
Other Operational Expenses		$ 10,000	$ 30,000	$ 15,000	$ 15,000	$ 20,000	$ 5,000	**$ 95,000**
Total Operational Infrastructure		$ 39,000	$ 80,378	$ 103,739	$ 103,739	$ 108,739	$ 93,739	**$ 529,334**
Indirect Cost/Administrative Overhead Rate	11.0%	$ 29,799	$ 21,192	$ 19,598	$ 19,158	$ 21,798	$ 16,078	**$ 127,623**
TOTAL INVESTMENTS		**$ 449,997**	**$ 477,763**	**$ 357,330**	**$ 258,366**	**$ 219,962**	**$ 162,242**	**$ 1,925,661**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Development of Care Management platform	$ 124,000.00

Total Development and Adaptation of EHR and Care Management System (Infrastructure Budget Line 2)	$ 124,000.00

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Development fee for care management platform to include configuration, ACO interoperability, billing and other CP specific platform initiatives. The total cost for development is allocated between BH CP and LTSS CP, for total of $200K. The allocation to LTSS is based on availability of funds within the $450K in either budget. A more specific allocation as based on antinipated utilization would be $120K to BH CP and $80K to LTSS CP.

For purposes of the Infrastructure Allocation, this cost is allocated fully to CHD as the services will be part of the general management of the CP. CHD is the managing member of ICP and has responsibility for coordinating general services including EHR.

Row 3 - Technology for Service Delivery

Description of Expense	Cost
Mobile technology, laptops, devices	$ 33,000.00
Total Technology for Service Delivery	$ 33,000.00

(Infrastructure Budget Line 3)	**$ 33,000.00**

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Providing staff with laptop for performance of care coordinatyion and electronic data recording. Expected costs are based on provider experience and vendor relationship for quantiity purchasing. It is estimated that individual set-ups of lap top, signature pads and sufficient print devices will cost approximately $1,000 per individual.

In the prep period, accomodations are being made for 33 individuals, building towards full capacity in later years.

The technology models/devicces expected are reflected in the following table. Several options/models have historically been used and are easily supported by our tecnolody departments. These are included herein as potential choices. Actual determination of which model is chosen (are chosen) will continue to be driven by availability and cost at time of purchase. Based on volume, ICP expects to leverage its purchasing power.

ICP confirms that 33 FTEs will be LTSS CP staff.

Type	Brand	Model
Laptop	Hewlett Packard	ProBook 400, 550, 850
Laptop	Hewlett Packard	EliteBook 8460P
Laptop	Lenovo	ThinkPad T530
Tablet	Microsoft	Surface Pro 4
Printer	Hewlett Packard	LaserJet, MFP, Color, BW
Printer/Copier	Canon	IR ADV 4545 I
Cell phones	Apple	iPhone 6s

Row 4 - Other Technology Expenses

Description of Expense	Cost

Total Other Technology Expenses (Infrastructure Budget Line 4)	

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Recruiter	$ 60,000.00	0.4	6	$ 12,000
				$ -
				$ -
				$ -
				$ -

				$	-
				$	-
				$	-
				$	-
	Total Salary	0.4		$	12,000
	Fringe rate	24.2%	Total Fringe	$	2,900
	Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)			**$**	**14,900**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

The recruiter is essential to implementing targeted activities intended to hire staff quickly and effectively. The recruiter is responsible for confirming roles, identifying core competencies and developing attractive, thoughtful job postings. Recruiter will use a number of online resources for advertising, including both broad-based and niche job boards

For purposes of the Infrastructure Allocation, this position /cost is allocated fully to CHD as the position will be part of the general management of the CP. CHD is the managing member of ICP and has responsibility for coordinating general services including employment of such positions.

Row 6 - Recruitment Expenses

Description of Expense	Cost
Advertisements, job fair expenses, web-based postings, materials, travel for recruitment	$ 20,000.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 20,000.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of

the CP's contract and how the costs were determined:

Expenses reflect routine activities and related costs based on provider experience as well as intentions to target certain markets and bilingual individuals. Costs are determined based on current experience and contracts for services (message boards, web services, newspapers). The total budget is broken down as follows:

Internet recruitment board (Indeed.com) $5K
Marketing Materials (professional informational brochures, billboards, general media) $7K
Job fairs & targeted recruitment - cost of venues and services (food/bevrages) & out of area travel $8K

For purposes of the Infrastructure Allocation, this cost is allocated 1/3 ($6,667) to each member of the consortium.

Row 7 - Training Expenses

Description of Expense	Cost
Total Training Expenses (Infrastructure Budget Line 7)	

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Row 8 - Retention Expenses

Description of Expense	Cost
Total Retention Expenses (Infrastructure Budget Line 8)	

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Business Start Up Costs - Prep Budget Period

Row 9 - Office Equipment

Description of Expense	Cost
Total Office Equipment (Infrastructure Budget Line 9)	

Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were determined:

Row 10 - Office Furniture

Description of Expense	Cost
Cubicles, desks, chairs, common area furniture, cabinets	$ 40,000.00
Total Office Furniture (Infrastructure Budget Line 10)	**$ 40,000.00**

Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:

Traditional administrative office furniture items in support of daily functions. Cost is based on provider experience and leveraging exisiting volume purchase agreements. It is estimated that furniture sufficient to support administrative functions (including above noted items) approximates $1K per individual for 40 positions at full operations.

For purposes of the Infrastructure Allocation, this cost is allocated 1/3 ($13,333) to each member of the consortium.

ICP confirms that 40 FTEs will be LTSS CP staff.

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total

Quality improvement manager	$ 70,000.00	1	4	$	23,333
				$	-
				$	-
				$	-
				$	-
				$	-
				$	-
				$	-
				$	-
	Total Salary	1		$	23,333
	Fringe rate	24.3%	Total Fringe	$	5,666
			Total Program Staffing including Fringe (Infrastructure Budget Line 12)	**$**	**29,000**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Quality Manager is responsible for creating and monitoring the QM plan; the manager will provide data and reports and staff the Quality Committee.

For purposes of the Infrastructure Allocation, this position /cost is allocated fully to CHD as the position will be part of the general management of the CP. CHD is the managing member of ICP and has responsibility for coordinating general services including employment of such positions.

Row 13 - Other Operational Expenses

Description of Expense	Cost
Professional business development	$ 10,000.00

Total Other Operational Expenses (Infrastructure Budget Line 13)	**$ 10,000.00**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Marketing material to educate clients, medical community, ACOs regarding CP services and ICP program. The full amount will be for professional material including brochures in various sizes and detail about the benefits of the CP program and how ICP can provide those services. It is anticipated that the brochures and material which will be mailed and otherwise distrubuted will cost $7K and media placement will cost $3K.

For purposes of the Infrastructure Allocation, this cost is allocated 1/3 ($3,333) to each member of the consortium.

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**11.00%**	**$ 29,799.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Administrative overhead required to effectively execute and coordinate the business functions of the community partner services is inclusive of following support services:

A) Finance administration
B) HR management
C) Qualitative performance measurement & reporting
D) Tax and cost report compliance
E) Third party billing and contract management
The 11% rate reflects historical experience of Innovative Care Partner's managing partner (CHD). CHD's current federal allowable indirect rate is 11.7%.

Community Partner Infrastructure Allocation Worksheet

	Innovative Care Partners, LLC						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL FUNDS AVAILABLE	$ 450,000	$ 630,000	$ 539,124	$ 527,001	$ 441,505	$ 175,928	$ 2,763,559
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
Consortium Entity or Affiliated Partner - CHD	$ 157,000	$ 45,000	$ -	$ -	$ -	$ -	$ 202,000
Consortium Entity or Affiliated Partner - ServiceNet	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner - Gandara	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ 157,000	$ 45,000	$ -	$ -	$ -	$ -	$ 202,000
Workforce Development							$ -
Consortium Entity or Affiliated Partner - CHD	$ 21,567	$ 33,939	$ 45,092	$ 43,758	$ 50,092	$ 37,758	$ 232,206
Consortium Entity or Affiliated Partner - ServiceNet	$ 6,666	$ 16,667	$ 14,667	$ 13,333	$ 19,667	$ 7,333	$ 78,333
Consortium Entity or Affiliated Partner - Gandara	$ 6,667	$ 16,667	$ 14,667	$ 13,333	$ 19,667	$ 7,333	$ 78,334
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ 34,900	$ 67,273	$ 74,426	$ 70,424	$ 89,426	$ 52,424	$ 388,873
Business Start Up Costs							$ -
Consortium Entity or Affiliated Partner - CHD	$ 63,099	$ 87,973	$ 53,189	$ 21,681	$ -	$ -	$ 225,943
Consortium Entity or Affiliated Partner - ServiceNet	$ 63,099	$ 87,973	$ 53,189	$ 21,681	$ -	$ -	$ 225,943
Consortium Entity or Affiliated Partner - Gandara	$ 63,099	$ 87,973	$ 53,189	$ 21,681	$ -	$ -	$ 225,943
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Business Start Up Costs	$ 189,298	$ 263,920	$ 159,568	$ 65,044	$ -	$ -	$ 677,830
Operational Infrastructure							$ -
Consortium Entity or Affiliated Partner - CHD	$ 32,333	$ 60,378	$ 93,739	$ 93,739	$ 95,405	$ 90,405	$ 465,999
Consortium Entity or Affiliated Partner - ServiceNet	$ 3,334	$ 10,000	$ 5,000	$ 5,000	$ 6,667	$ 1,667	$ 31,668
Consortium Entity or Affiliated Partner - Gandara	$ 3,333	$ 10,000	$ 5,000	$ 5,000	$ 6,667	$ 1,667	$ 31,667
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ 39,000	$ 80,378	$ 103,739	$ 103,739	$ 108,739	$ 93,739	$ 529,334
TOTAL INVESTMENTS	$ 420,198	$ 456,571	$ 337,733	$ 239,207	$ 198,165	$ 146,163	$ 1,798,037

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	CC/CM Electronic Health Record Development	Fully operational CP-specific Electronic Record System	11/01/17	03/01/18	Testing completed	Successful testing			Electronic Health Record Training	Users are certified		
Technology	CP Reporting System	Initial set of performance and quality reports are developed and tested	01/01/18	03/01/18	Testing completed	Successful testing			Initial report set established	QM Committee Approval		
Technology												
Technology												
Workforce Development	CP Recruitment Strategy and Plan	Successful recruitment resulting in adequately staffed program at start-up	11/01/17	06/01/18	Management staff hired	Management staff hired			Staff hired per Prep Period Budget	Staff-enrollee ratio is met for projected 6/1/18 enrollment		
Workforce Development	CP Pre-Service Orientation and Training Program	Training Program is implemented at start up	01/01/18	05/01/18	Pre-Service Training Plan completed	Training plan approved by consortium entities			Initial staff are trained per plan	Training participation documentation		
Workforce Development												
Workforce Development												
Business Start Up Costs	CP Hub offices set up	Operational CP offices established to assure access in each Service Area	11/01/17	03/01/18	Minimum 4 offices to serve all Service Areas	Executed lease/rental agreements			Minimum 6 offices to serve all Service Areas	Executed leases/agreements; offices are fully equipped/operational		
Business Start Up Costs												
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Quality Management System	Performance and Quality Improvement (PQI) Plan is operational	01/01/18	05/01/18	PQI Plan completed	QM Committee established; PQI Plan approved			12-Month QM Monitoring and Review Calendar Completed	QM Committee Approval		
Operational Infrastructure												
Operational Infrastructure												
Operational Infrastructure												

Section 7.5 Initial DSRIP Participation Plan

A. Executive Summary

1. **Goals and Challenges:** The five-year business plan for implementing the LTSS CP program, in compliance with the requirements of Section 4.1 of Attachment A, reflects the following goals:

a. Supporting Enrollees with complex LTSS and behavioral health needs, brain injury or cognitive impairments, physical disabilities, intellectual and developmental disabilities, including autism, older adults with LTSS needs, and children and youth with LTSS needs;
b. Improving the care experience, continuity and quality of care for Enrollees by holistically engaging Enrollees in care coordination and care management activities;
c. Facilitating collaboration between ACOs and MCOs and community-based organizations to break down silos and promote integrated care so that the social determinants of health are more effectively addressed for members with LTSS needs;
d. Working collaboratively with ACOs and MCOs to avoid duplication of care coordination and care management services for the LTSS population; and
e. Promoting and supporting the values of Community First, self-determination principles, and cultural competence in providing care coordination and care management services to members with LTSS needs.

ICP's business plan will incorporate strategies that address anticipated challenges, including, as examples, the following:

Potential Challenge	**Solutions/Strategies**
Enrollee Resistance to LTSS CP services	1. Effective matching of Enrollees to Care Coordinators in terms of language, cultural affinity, and experience with presenting Enrollee conditions 2. Enrollment Specialists and Care Coordinators trained in Motivational Interviewing (MI); 3. Collaboration with Enrollee's PCP, family members, and other care givers.
Personnel Recruitment and Retention	1. Comprehensive staff recruitment plan including creative use of social media and other outreach avenues (See Sections 7.5.E below); 2. Apply "Employer of Choice" strategies that have helped earn CHD "Best Non-profit Workplace" awards for the past two years.
ACO and MCO Engagement	1. Leverage existing positive relationship of the Consortium Entities with each ACO and MCO; 2. Establish collaboration processes, such as monthly Joint Operating Committee meetings, beginning in the Preparation Period (See Section 7.5.J. below).
Risk Sharing	1. Establish effective data analysis and reporting systems to allow timely monitoring of quality and financial measures; 2. Maintain adequate cash and liquidity ratios.
Technology	1. Devote adequate resources for information system software and hardware that meet contract requirements; 2. Maintain active involvement with State and local planning groups working toward interoperability among entities and connection to Mass HiWay; 3. Involve content experts within Bidder's LTSS CP program with eHana design engineers to continuously improve the CC/CM platform during the Preparation Period and beyond.

A list of activities that will be accomplished in each contract year is provided in Section 7.5.F below (Implementation Plan and Timeline).

2. The number of Assigned and Engaged Enrollees the Bidder intends to support under the Contract: ICP proposes to serve a maximum caseload of ~~4,159~~2,700 Enrollees who reside within the seven Service Areas comprising the Western Region. It is expected that this target would be reached by the middle of Budget Year 2 (See Budget Narrative, Appendix B).

3. Proposed Western Region Service Areas: Adams, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, and Westfield.

4. ICP plans to operationalize the CP program and time frames associated with implementing such activities: A summary of significant components of the plan for operationalizing the LTSS CP program is provided below:

Nov. 2017- ~~March~~ June 2018 – Preparation Period: (1) Hire Program Director by ~~November~~ December 1 and implement staff recruitment plan (See Section 7.5.E below); (2) Work with IS vendor (eHana) to complete customized Care Coordination/Care Management IS platform; (3) Finalize governance policies and procedures with Consortium Entities; (4) Equip Hub offices; (5) establish Quality Committee and Consumer Advisory Board; and (5) Conduct initial outreach meetings with ACOs and MCOs, execute Memorandum of Agreements, and establish referral and communication pathways and protocols.

~~April~~ June – Dec. 2018 – Budget Period 1: (1) Continue to hire, train, and deploy CP personnel to meet member enrollment needs; (2) Implement program and quality data collection and reporting processes; (3) Maintain monthly joint operating meetings with ACOs and MCOs; and (4) Monitor Enrollee assignment process and Hub caseloads and adjust as needed.

Budget Periods 2-5: Continue to monitor all program and quality measures and adjust as needed.

Please also refer to Section 7.5.F- Implementation Plan, below, for a more detailed plan

Attachment D:Community Partners Service Area Coverage Form **(Revised)**

Please indicate for which Service Areas the Bidder is bidding. Please estminate the number of members the Bidder will have the capacity to support in each Service Area. ***Innovative Care Partners LTSS CP***

Region	Service Area	Bidder Selected Service Areas	Estimated Number of members the Bidder will have the capacity to support within each Service Area
Greater Boston Region	BOSTON - PRIMARY		
	REVERE		
	SOMERVILLE		
	QUINCY		
Northern Region	BEVERLY		
	GLOUCESTER		
	HAVERHILL		
	LAWRENCE		
	LOWELL		
	LYNN		
	MALDEN		
Southern Region	ATTLEBORO		
	BARNSTABLE		
	BROCKTON		
	FALL RIVER		
	FALMOUTH		
	NANTUCKET		
	NEW BEDFORD		
	OAK BLUFFS		
	ORLEANS		
	PLYMOUTH		
	TAUNTON		
	WAREHAM		
Central Region	ATHOL		
	FRAMINGHAM		
	GARDNER-FITCHBURG		
	SOUTHBRIDGE		
	WALTHAM		
	WORCESTER		
Northern Region	BEVERLY		
	GLOUCESTER		
	HAVERHILL		
	LAWRENCE		
	LOWELL		
	LYNN		
	MALDEN		
Western Region	ADAMS	X	59
	GREENFIELD	X	105
	HOLYOKE	X	317
	NORTHAMPTON	X	125
	PITTSFIELD	X	176
	SPRINGFIELD	X	1,591
	WESTFIELD	X	327

E. Personnel and staffing

1. An **organizational chart** for the LTSS CP initiative is included as Attachment 2 (Revised).

2. **Sample staffing model:** Each of the three Consortium Entities and two Material Subcontractors will operate one Service Hub each to serve Engaged Enrollees in the proposed service areas listed in Attachment D (Revised). These Hubs will all operate under a single set of program policies and procedures (LTSS CP Operating Manual), as described in Section 7.2.

Figure 2

LTSS CP Sample Staffing Model

Service Hubs	Service Areas- # of Enrollees	Care Coordination Supervisor	Care Coordinator (CCs)
Five Hubs: CHD Service Net Gandara Center Bershire ARC Pathlight	~~4,159~~2,700 Enrollees	~~8~~6.5 FTE CC Supervisors	~~46~~30 FTE CCs
~~CHD Hub 2 Teams~~	~~Springfield: 1,200~~	~~2.5 Supervisors~~	~~13 CCs~~
~~ServiceNet Hub 2 Teams~~	~~Greenfield: 162 Holyoke: 265 Northampton: 193 Westfield: 504~~	~~2.0 Supervisors~~	~~12 CCs~~
~~Gandara Hub 2 Teams~~	~~Holyoke: 223 Springfield: 900~~	~~2.0 Supervisors~~	~~12 CCs~~
~~Berkshire ARC 1 Team~~	~~Adams: 91 Pittsfield: 271~~	~~0.5 Supervisor*~~	~~4 CCs~~
~~Pathlight 1 Team~~	~~Springfield: 350~~	~~0.5 Supervisor*~~	~~4 CCs~~

~~* Or 1.0 Supervisor and 3.5 CCs, with Supervisor maintaining 50% caseload~~

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3. Recruitment Plan: Innovative Care Partners (ICP) will implement a robust and dynamic recruitment plan to ensure that all key roles are filled in anticipation of an April 1, 2018 start date. The CHD human resources department includes dedicated recruitment staffing, led by a full-time Recruiter, that will conduct LTSS CP recruitment activities, with support from HR departments at ServiceNet, Gandara Center, Berkshire County ARC, and Pathlight. The Program Director will be hired by ~~November~~ December 1, 2017 to direct and oversee all aspects of program planning and development during the Preparation Period. Care Coordinator Supervisors will by hired by ~~February~~ April 2018. These individuals, working closely with the Program Director, will help screen and hire the Care Coordinators.

The recruitment process begins with confirming roles, identifying core competencies and developing attractive, thoughtful job postings. Recruitment activities that will be centralized at ICP include sourcing, processing online applications, and conducting initial candidate

screening and interviews. Final interviews and job offers will be accomplished at the Consortium Entity or Material Subcontractor where the staff person will be assigned.

ICP will employ a wide variety of candidate sourcing and outreach strategies, including:

- Social media outlets such as LinkedIn, Facebook, Twitter;
- Professional associations to reach individuals with specific educational and professional background;
- Professional and civic associations to reach minority and bilingual candidates, such as Spanish Nurses Association, Vietnamese American Civic Association, National Association of Puerto Rican and Hispanic Social Workers, New North Citizens Council, Recovery Learning Center, and the Transformation Center;
- Job fairs held in each proposed service area;
- Direct mail using mail lists from professional associations, licensing and certification agencies, etc.;

4. Cultural and Linguistic Staff Diversity: Innovative Care Partners (ICP) will actively recruit staff from a variety of cultural and linguistic communities, with a special focus on bi-lingual English- and Spanish-speaking candidates. Gandara Center employs a full-time bilingual/bicultural Recruiter who will lead candidate sourcing and outreach activities, such as organizing and attending job fairs, screening, and conducting initial interviews. In addition, ICP and Consortium Member staff will travel to Puerto Rico and Spain in order to reach a qualified pool of candidates. Recruitment at universities on Puerto Rico has been a successful recruiting tool and we will also host job fairs and other recruiting events there as well. ICP also has had success working with professional and civic associations to reach those candidates in targeted cultural or linguistic communities. Examples of organizations which have access to diverse communities include the Spanish Nurses Association, Russian Community Association, Vietnamese American Civic Association, National Association of Puerto Rican and Hispanic Social Workers, and New North Citizens Council. ICP will also recruit and hire qualified candidates with lived experience, including persons in recovery from mental illness and substance use disorders.

5. Staff Orientation and Training: Innovative Care Partners (ICP) recognizes that planning and implementing a comprehensive staff orientation and training plan is critical to the success of the LTSS CP program. The components of the proposed plan include: (1) orientation to CP goals, policies, procedures and individual staff position expectations and to relevant Hub agency policies and procedures and safety, privacy, and other compliance training; (2) specialized care coordination and care management training; (3) orientation to individual CP roles; and (4) management training for CP leaders. A Training Specialist will be hired to plan and oversee the CP Training and Orientation Plan. This position will report to the CP Quality Manager, but will also work closely with the CHD Vice President of Human Resources and the CP Program Director.

All new CP personnel will undergo a standardized four week pre-service orientation and training program that will consist of group sessions, individual on-line learning through the Relias e-learning platform, and job shadowing.

a. **Orientation and Universal Training (conducted during the pre-service, orientation period, at CP Central Office and at individual host Hub):**
   i. Orientation to the LTSS CP program: mission, values, policies and procedures, role descriptions, program organization;
   ii. Training in eHana Care Coordination/Care Management Information System;
   iii. Orientation to Consortium Entity Hubs: Host agency mission, values, policies and procedures, organization, employment rules and benefit programs;
   iv. Relias web-based curriculum: HIPAA, 42 CFR, and other confidentiality/privacy requirements; universal precautions and safety for human service workers; cultural diversity and human rights; and sexual harassment;
   v. Human rights training, mandated by the Department of Mental Health; and
   vi. First Aid and CPR Certification.

b. Specialized Behavioral Health and Community Partner (CP) Training (Initiated in the pre-service, orientation period and continuing during first year of employment):

i. Motivational Interviewing (MI) – An eight-hour training for Clinical Care Managers, Care Coordinators, Enrollment Manager, and Enrollment Specialists;

ii. Integrated Care Management Certificate Program – A 20-module, on-line learning program, conducted by UMASS Medical Center, for Clinical Care Managers and Care Coordinators. The program develops general skills for engaging Enrollees, promoting their activation to improve their own health, and general medical and behavioral health skills to be able to connect Enrollees to appropriate services, to address questions, to teach healthy living and support patient-centered treatment plans;

iii. Non-Violent Crisis Intervention Training: Eight hour program, conducted by the Crisis Prevention Institute (CPI), for Clinical Care Managers and Care Coordinators;

iv. Screening, Brief Intervention, Referral, and Treatment (SBIRT): Offered by the National Council for Behavioral Health, this 1 ½ hour online training in the use of SBIRT tools will assist Clinical Care Managers and Care Coordinators to assist Enrollees with possible alcohol and other substance use issues;

v. Recovery Support Navigation: Two Care Coordinators on each Care Coordination Team will attend five-day Recovery Coach Academy, sponsored by AdCare Educational Institute. The Academy teaches the principles, philosophy, and functions of Recovery Coaches; and

vi. EOHHS-Mandated or Recommended Training: ICP will cooperate with, and support the provision of, CP training programs that EOHHS may develop, sponsor, or otherwise require during the period of the Contract.

c. CP Role Orientation and Job Shadowing (conducted during the pre-service period): Each new CP staff person will spend at least one week working alongside seasoned workers to learn the details of their role. The first "wave" of staff who are hired in the Preparation Period and early part of Budget Year 1 will receive simulated training, including Enrollee role playing.

d. Management Training: (a) three-hour pre-service orientation to administrative services, including Fiscal, Human Resources, IT, Organizational Excellence, Development and Marketing; and (b) participation in CHD-sponsored management training programs.

6. Staff Retention Strategies

Staff retention and engagement efforts start from day one at Innovative Care Partners (ICP). Our orientation and onboarding efforts connect and ground new staff in the important mission of the organization and make the most of their enthusiasm and energy. Amidst all of the paperwork and policies is the strong message about mission and values that drives the work that we do in the community.

ICP offers highly competitive compensation and benefits, both in traditional and non-traditional ways. Our salaries are at or above market rates and we continually review both internal and external equity to ensure that we can attract and retain the highest caliber staff. We provide sign-on and referral bonus for difficult to fill positions and offer bonuses and incentives for our clinical staff, along with reimbursement for their professional licensure. We have been able to provide regular bonuses, gift cards, and other financial recognition of the good work of our staff.

Insurance benefits are an important part of our benefits package and Innovative Care Partners is committed to contributing toward the majority of the health and dental insurance premiums on behalf of our staff. Life insurance as well as both short and long-term disability coverage are offered to staff at full company expense and we provide important retirement plan benefits as well. Caring about our staff's health goes well beyond insurance coverage – Innovative Care Partners has vibrant wellness activities, incentives, and initiatives in order to support our staff in a myriad of ways. From non-smoking support and incentives to health-related trainings to Employee Assistance Programs, we support our staff in their total health and wellness so that they can, in turn, focus on the support of those we serve.

We also recognize that in this difficult work, it's important for staff to have a break and to have fun. We provide generous paid time off benefits so that our staff can rejuvenate and recharge and we understand the importance of work/life balance. Whenever possible, we provide flexibility and appreciation for personal time. While staff are at work though, we also ensure that they are recognized for their good work and we highlight our appreciation with a variety of recognition awards and events throughout the year, including employee of the month, Star Awards, work anniversary acknowledgments and staff social events.

Another important retention strategy is ensuring that staff are well trained, well supervised, and well prepared for the next stage in their careers. To that end, we support a strong learning culture at Innovative Care Partners with an emphasis on professional development and training. With both extensive in-person and online training opportunities, CHD staff are able to expand their clinical, administrative and management knowledge. On the job training, in-house expertise, clinical supervision and an electronic training module provide staff an array of content areas as well as forums to learn about the latest treatment models, stay abreast of compliance and safety standards, and develop important supervisory and management skills. Our organization size also provides unique opportunities for mobility – both clinical and managerial advancement are common.

Communication and participation are important for staff to feel a commitment to an organization. Innovative Care Partners has a strong human resources department to provide additional support and assistance to staff on a number of issues as well as formal open door and grievance policies to ensure that people are heard and listened to throughout their employment. We actively seek involvement from staff in agency-wide committees that provide guidance and direction to management. There are also a number of communication tools – email, intranet, staff meetings, open forums, etc. – that enable staff to provide input to management and for management to inform staff about issues of importance to the work that we do.

Finally, ICP and its Consortium Entities are strong, stable agencies with reputations for quality services. Staff want to be part of our creative, mission-driven organization. And the organization seeks staff that are active participants and truly engaged in the important work and ongoing success of those we serve. We are committed to providing staff with a unique employment opportunity based on mutual respect and collaboration. We have created a culture where joint problem-solving, entrepreneurial service delivery, and positive relationships thrive. All of that takes regular care and attention. Therefore, Innovative Care Partners considers retention strategies in a very broad manner – there are many things that impact someone's experience at work and keep them enthusiastic and excited about the work they do and where they do it. We strive to develop strategies that support a highly engaged staff, foster creativity and enthusiasm, and recognize the individual strengths and collective power of staff to enhance people's lives.

F. Implementation Plan and Timeline (Revised)

Innovative Care Partners (ICP) shall attach timelines that display ICP's monthly implementation plans for the Preparation Budget Period, and quarterly implementation plans for each subsequent Budget Period. The timelines shall include all necessary operational activities to meet the Contractor Requirements described in Attachment A.

Preparation Period:

Nov 2017	~~• Program Director Hired; Begins policy and procedures (P&Ps) development~~ ~~• Governing Board begins review and approval of initial set of P&Ps~~ • Bidder/Vendor IT Work Team meets weekly on software customization (Vendor contract executed and project plan developed in Sept-October) ~~• Program Director and Consortium Entity leaders initiate outreach to ACOs and MCOs; hold initial meeting with each ACO; begin negotiating written Agreements~~ • ~~Program Director develops outreach/marketing materials and strategies w/CHD Marketing Department technical assistance and support~~
Dec 2017- Jan . 2018	• Program Director Hired; Begins policy and procedures (P&Ps) development • Governing Board begins review and approval of initial set of P&Ps • Program Director and Consortium Entity leaders initiate outreach to ACOs and MCOs; hold initial meeting with each ACO; begin negotiating written Agreements • Program Director develops outreach/marketing materials and strategies w/CHD Marketing Department technical assistance and support • Program Director continues policy and procedures development • Governing Board continues review and approval of P&Ps • Bidder/Vendor IT Work Team meets weekly on software customization project • MCO/ACO Agreements are executed; Program Director establishes monthly joint operating meeting structure with each ACO; solicits ACO suggestions on Enrollee outreach/engagement
~~Jan~~ Feb 2018	• Quality Manager hired; begins working with Program Director to establish Quality Committee; begins work with Consortium Entity QM leaders to design CP CQI Plan • Governing Board meets, reviews and approves new policies and project plans • Enrollment Manager hired; begins designing outreach/engagement plan w/ Program Director and CHD Marketing Dept • Program Director and Enrollment Manager bring draft outreach/engagement plan to monthly ACO joint operating meetings for input • IT Work Team presents test-mode demonstration of customized CC/CM software to Governing Board, Program Director and Consortium Entity personnel • Program Director initiates active outreach to community resource/collaboration agencies w/support from CHD Marketing Department • Consumer Advisory Board membership recruitment begins
~~Feb~~ March 2018	• Care Coordinator Supervisors are hired for each Hub; • Training Specialist is hired; • Quality Manager presents draft CQI plan for Committee feedback and approval • Program Director presents Policy Manual for Governing Board approval (that addresses all requirements of EOHHS Contract) • Program Director and Enrollment Manager finalize outreach/engagement plan and communicates it at each ACO joint operating meetings • IT Work Team beta tests customized CC/CM software; develops specs for initial report set w/Quality Manager, Program Director and Care Coordinator Supervisors • Program Director, Care Coordinator Supervisors, and Enrollment Manager continue outreach to community resource/collaboration agencies w/support from CHD Marketing Department • Consumer Advisory Board holds kick-off meeting • Quality Committee holds kick-off meeting

	• Business Associate Agreements (BAA) are executed with each Consortium Entity, Material • Subcontractor, IT Vendor, and other applicable third parties
~~March~~ April 2018	• One Enrollment Specialist is hired and trained • Personnel is hired and trained to staff one Care Coordination Team in each Hub • IT Work Team installs CC/CM software and trains teams at each Hub • Enrollment Department w/IT support conducts test with EOHHS and each ACO for transmittal of Assigned Enrollee data • Consumer Advisory Board holds meets and reviews final implementation plan • Quality Committee meets and recommends final CQI Plan for Budget Period 1 • Governing Board approves Year 1 CQI Plan

Budget Year 1:

~~April – June~~June 2018	• Enrollment Dept receives initial transmittal of Assigned Enrollees from MassHealth, conducts outreach to members consistent with outreach/engagement plan, and makes assignments to each Hub following approved assignment criteria • Additional Care Coordinators are hired and trained each month based on number of new Assigned Enrollees • IT Team troubleshoots and resolves any system and end user problems • Continued outreach to ACOs to facilitate and generate Enrollee Assignments; monthly joint operating conference calls with each ACO and MCO to address issues and facilitate coordination • Continued outreach to community resources • Quality Manager analyzes Month 1 enrollment and engagement data and distributes first dashboard reports to each Hub; Assistant Directors • Quality Committee meets monthly to review reports • Consumer Advisory Board meets to review Program Director report on implementation progress and provides suggestions to address outreach, engagement, and other challenges • Progress report submitted to EOHHS as required
July – Sept 2018	• Second Enrollment Specialist hired and trained • Additional CCs are hired and trained each month based on number of new Assigned Enrollees • Joint operating conference calls with each ACO and MCO to address issues and facilitate coordination continue on quarterly basis • Quality Manager analyzes Quarter 1 program performance and quality data and distributes first dashboard reports to each Hub; Assistant Directors implement action plans to address below target measures • Year 1 CQI initiative to increase Enrollee engagement rate is conducted; results are reported to Quality Committee and Governing Board • Consumer Advisory Board meets to review Program Director report on implementation progress and provides suggestions to address outreach, engagement, and other challenges • Progress report submitted to EOHHS as required
Oct-Dec 2018	• Enrollee mobile app launched on pilot basis • Additional Care Coordinators are hired and trained each month based on number of new Assigned Enrollees • Joint operating conference calls with each ACO and MCO to address issues and facilitate coordination continue on quarterly basis • Quality Manager analyzes Quarter 2 program performance and quality data and distributes first dashboard reports to each Hub; Teams implement action plans to address below target measures • Continue tracking data related to CQI initiative and implement action plan as needed; • Report results to Quality Committee and Governing Board • Consumer Advisory Board meets to review Program Director report on implementation progress and provides suggestions to address outreach, engagement, and other challenges • Progress report submitted to EOHHS as required

Year 2:

Jan-Mar 2019	• Mobile app pilot results reviewed, IT dept makes changes as needed, and app is rolled out to all interested Enrollees • Program Director produces Year 1 report for Board and EOHHS, incorporating quality and performance data from Quality Manager • Quality Committee and Consumer Advisory Board review Year 1 results and provide suggestions to address challenges • First Year 2 CQI initiative is planned, with input from Quality Committee and Consumer Advisory Board • Quarterly joint operating meetings with ACOs and MCOs continue • Consumer and ACO/MCO surveys are designed, with input from Quality Committee and Consumer Advisory Board, approved by EOHHS, and distributed • Planning for first annual Community Partners conference begins • Quality Committee and Consumer Advisory Committee meet • Progress report submitted to EOHHS as required
April-June 2019	• Consumer and ACO/MCO survey results are analyzed and reported to Quality Committee, Consumer Board ,Governing Board, and EOHHS; action plans are developed to address areas for improvement • First annual CP conference held • IT enhancements related to interoperability, data analytics, and predictive analysis are tested and installed on CC/CM platform • Quarterly joint operating meetings with ACOs and MCOs continue • First Year 2 CQI initiative is implemented • Quarterly joint operating meetings with ACOs and MCOs continue • Quality Committee and Consumer Advisory Committee meet • Progress report submitted to EOHHS as required
July-Sept 2019	• Second Year 2 CQI initiative is planned • Quarterly joint operating meetings with ACOs and MCOs continue • Quality Committee and Consumer Advisory Board meet • Joint operating meetings with ACOs and MCOs are held • Progress report submitted to EOHHS as required
Oct-Dec 2019	• Second Year 2 CQI initiative is implemented • Quarterly joint operating meetings with ACOs and MCOs continue • Quality Committee and Consumer Advisory Board meet • Joint operating meetings with ACOs and MCOs are held • Progress report submitted to EOHHS as required

Year 3:

Jan-Mar 2020	• Program Director produces Year 2 report for Board and EOHHS, incorporating quality and performance data from Quality Manager • Quality Committee and Consumer Advisory Board review Year 2 results and provide suggestions to address challenges • First Year 3 CQI initiative is planned, with input from Quality Committee and Consumer Advisory Board • Quarterly joint operating meetings with ACOs and MCOs continue • Consumer and ACO/MCO surveys are distributed • Planning for annual Community Partners conference begins • Quality Committee and Consumer Advisory Committee meet • Progress report submitted to EOHHS as required
April-June 2020	• Consumer and ACO/MCO survey results are analyzed and reported to Quality Committee, Consumer Board, Governing Board, and EOHHS; action plans are developed to address areas for improvement • Second annual CP conference held • Quarterly joint operating meetings with ACOs and MCOs continue

	• Second Year 3 CQI initiative is implemented • Quarterly joint operating meetings with ACOs and MCOs continue • Quality Committee and Consumer Advisory Committee meet • Progress report submitted to EOHHS as required
July-Sept 2020	• Second Year 3 CQI initiative is planned • Quarterly joint operating meetings with ACOs and MCOs continue • Quality Committee and Consumer Advisory Board meet • Joint operating meetings with ACOs and MCOs are held • Progress report submitted to EOHHS as required
Oct-Dec 2020	• Second Year 3 CQI initiative is implemented • Quarterly joint operating meetings with ACOs and MCOs continue • Quality Committee and Consumer Advisory Board meet • Joint operating meetings with ACOs and MCOs are held • Progress report submitted to EOHHS as required

Year 4:

Jan-Mar 2021	• Program Director produces Year 3 report for Board and EOHHS, incorporating quality and performance data from Quality Manager • Quality Committee and Consumer Advisory Board review Year 3 results and provide suggestions to address challenges • First Year 4 CQI initiative is planned, with input from Quality Committee and Consumer Advisory Board • Quarterly joint operating meetings with ACOs and MCOs continue • Consumer and ACO/MCO surveys are distributed • Planning for annual Community Partners conference begins • Quality Committee and Consumer Advisory Committee meet • Progress report submitted to EOHHS as required
April-June 2021	• Consumer and ACO/MCO survey results are analyzed and reported to Quality Committee, Consumer Board ,Governing Board, and EOHHS; action plans are developed to address areas for improvement • Third annual CP conference held • Quarterly joint operating meetings with ACOs and MCOs continue • Second Year 4 CQI initiative is implemented • Quarterly joint operating meetings with ACOs and MCOs continue • Quality Committee and Consumer Advisory Committee meet • Progress report submitted to EOHHS as required
July-Sept 2021	• Second Year 4 CQI initiative is planned • Quarterly joint operating meetings with ACOs and MCOs continue • Quality Committee and Consumer Advisory Board meet • Joint operating meetings with ACOs and MCOs are held • Progress report submitted to EOHHS as required
Oct-Dec 2021	• Second Year 4 CQI initiative is implemented • Quarterly joint operating meetings with ACOs and MCOs continue • Quality Committee and Consumer Advisory Board meet • Joint operating meetings with ACOs and MCOs are held • Progress report submitted to EOHHS as required

Year 5:

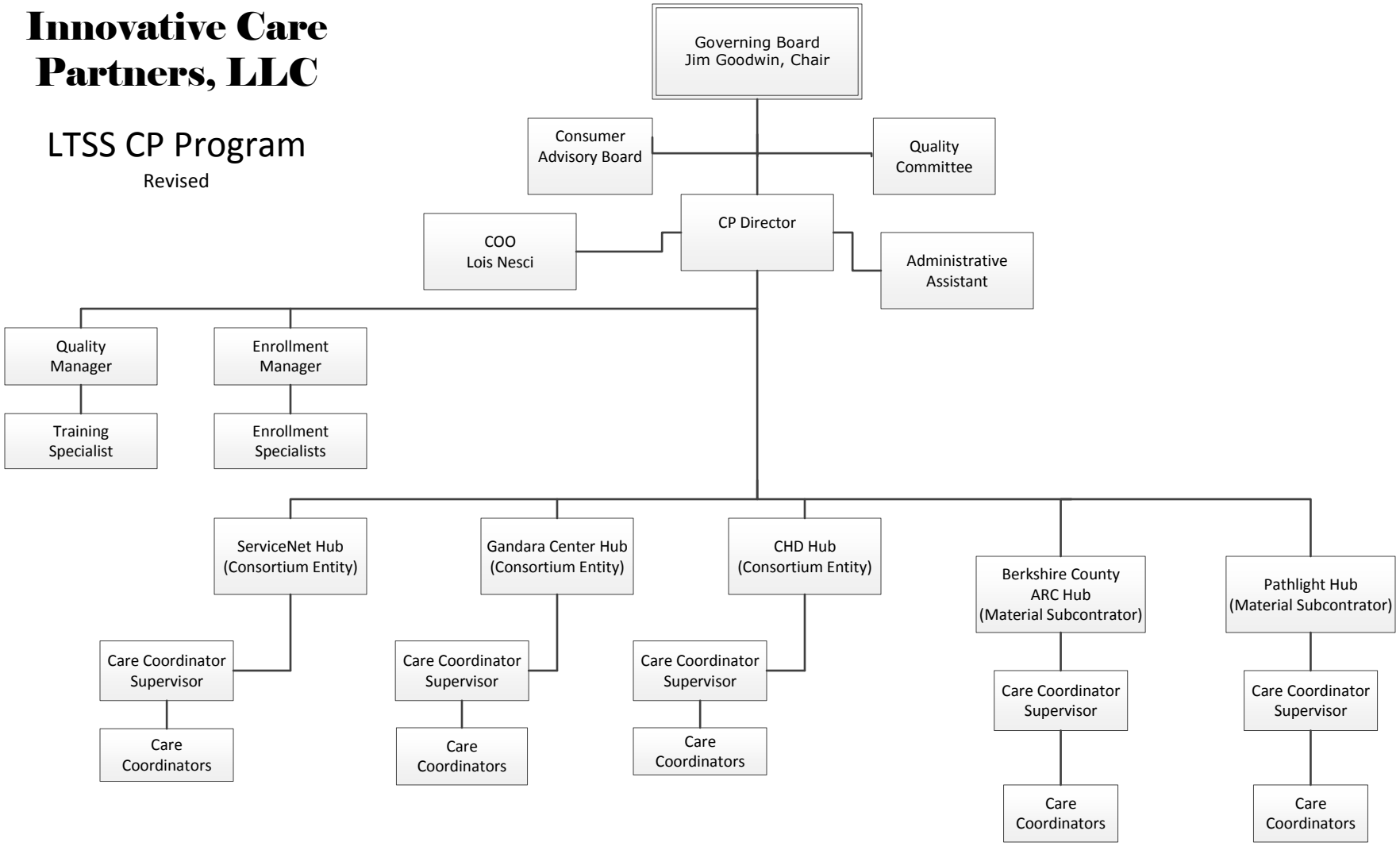
Jan-Mar 2022	• Program Director produces Year 4 report for Board and EOHHS, incorporating quality and performance data from Quality Manager • Quality Committee and Consumer Advisory Board review Year 4 results and provide suggestions to address challenges

	• First Year 5 CQI initiative is planned, with input from Quality Committee and Consumer Advisory Board • Quarterly joint operating meetings with ACOs and MCOs continue • Consumer and ACO/MCO surveys are distributed • Planning for annual Community Partners conference begins • Quality Committee and Consumer Advisory Committee meet • Progress report submitted to EOHHS as required
April-June 2022	• Consumer and ACO/MCO survey results are analyzed and reported to Quality Committee, Consumer Board ,Governing Board, and EOHHS; action plans are developed to address areas for improvement • Fourth annual CP conference held • Quarterly joint operating meetings with ACOs and MCOs continue • Second Year 5 CQI initiative is implemented • Quarterly joint operating meetings with ACOs and MCOs continue • Quality Committee and Consumer Advisory Committee meet • Progress report submitted to EOHHS as required
July-Sept 2022	• Second Year 5 CQI initiative is planned • Quarterly joint operating meetings with ACOs and MCOs continue • Quality Committee and Consumer Advisory Board meet • Joint operating meetings with ACOs and MCOs are held • Progress report submitted to EOHHS as required
Oct-Dec 2022	• Second Year 5 CQI initiative is implemented • Quarterly joint operating meetings with ACOs and MCOs continue • Quality Committee and Consumer Advisory Board meet • Joint operating meetings with ACOs and MCOs are held • Progress report submitted to EOHHS as required

Innovative Care Partners, LLC

LTSS CP Program

Revised



Community Partner Program Budget Report

Boston LTSS Community Partners

	Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
	Estimated Enrollees- Start of Period (All Enrollees)		0	1,296	1,624	1,624	1,624	
	Estimated Enrollees - End of Period (All Enrollees)		1,296	1,624	1,624	1,624	1,624	
	Estimated Enrollees - Monthly Average		1,120	1,644	1,624	1,624	1,624	
	Total Estimated Program Revenue		**$ 627,411**	**$ 1,577,792**	**$ 1,558,800**	**$ 1,558,800**	**$ 1,558,800**	**$ 6,881,603**
	At- Risk Withhold Rate			0%	0%	0%	0%	
	Withhold funds			$ -	$ -	$ -	$ -	$ -
	Revenue for Operations		$ 627,411	$ 1,577,792	$ 1,558,800	$ 1,558,800	$ 1,558,800	$ 6,881,603

	Program Expenses		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
1	**Salary**		$ 170,105	$ 697,697	$ 1,270,335	$ 1,146,970	$ 1,145,802	$ 1,167,637	$ 5,598,545.72
2	**Fringe**		$ 40,826	$ 167,447	$ 304,880	$ 275,273	$ 274,992	$ 280,233	$ 1,343,651.77
	Total Personnel Costs		$ 210,931	$ 865,144	$ 1,575,216	$ 1,422,242	$ 1,420,794	$ 1,447,870	$ 6,942,197
3	**Training & Professional Development**		$ 1,513	$ 6,207	$ 11,302	$ 10,204	$ 10,194	$ 10,388	$ 49,809
4	**Travel**		$ 3,566	$ 14,627	$ 26,631	$ 24,045	$ 24,021	$ 24,478	$ 117,368
5	**Equipment**		$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	**Supplies**		$ 1,297	$ 5,320	$ 9,687	$ 8,747	$ 8,738	$ 8,904	$ 42,693
7	**Contract Services** (consulting, professional)		$ -	$ -	$ -	$ -	$ -	$ -	$ -
8	**Software licensing**		$ -	$ -	$ -	$ -	$ -	$ -	$ -
9	**Telecommunications**		$ -	$ -	$ -	$ -	$ -	$ -	$ -
10	**Occupancy** (rent, utilities, maintenance)		$ 8,053	$ 33,030	$ 60,139	$ 54,299	$ 54,243	$ 55,277	$ 265,040
11	**Other**		$ -	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 25,000
	Total Direct Costs		$ 225,361	$ 929,328	$ 1,687,975	$ 1,524,537	$ 1,522,989	$ 1,551,917	$ 7,442,107
12	**Indirect Cost/Administrative Overhead**	**12.1%**	**$ 27,170**	**$ 112,040**	**$ 203,503**	**$ 183,799**	**$ 183,613**	**$ 187,100**	$ 897,225
	TOTAL EXPENSES		$ 252,530	$ 1,041,369	$ 1,891,478	$ 1,708,336	$ 1,706,602	$ 1,739,018	$ 8,339,333
	Surplus/Shortfall		*$ (252,530)*	*$ (413,958)*	*$ (313,686)*	*$ (149,536)*	*$ (147,802)*	*$ (180,218)*	*$ (1,457,730)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Executive Director	$ 150,000.00	0.8	4.5	$ 45,000
LTSS Program Manager	$ 75,000.00	1	2.10	$ 13,105
LTSS Care Coordinator	$ 48,000.00	14	2.0	$ 112,000
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary (Program Budget Line 1)		**15.8**		**$ 170,105**

For each position listed above, provide a brief statement of the position's responsibilities:

Executive Director: responsible for the oversight and operations of BLTSSCP. The role collaborates with the governing board and the member organizations and is responsible for all administrative and related activities including management of the human, fiscal and community resources necessary to ensure that the Community Partners program is planned and managed to the highest standards of the industry. The Executive Director represents BLTSSCP to all external constituencies.

LTSS Program Manager: This position will be responsible for managing sub-contracts with the 7 BLTSSCP member organizations that include program guidelines and will develop operational processes internal to BLTSSCP and with ACO/MCOs.

LTSS Care Coordinators: Each of the 7 organizations will hire an LTSS Care Coordinator April 1 to be trained and prepared to begin serving Enrollees on June 1, 2018.

** Funds for hiring an LTSS Care Coordinator in advance roll-over to the Infrastructure budget and are included in the Infrastructure Allocation (tab 5). Each of the 7 organizations is provided with the same amount of funding.

Row 2 - Fringe

Fringe Item	Total Salary	Fringe	Fringe
Fringe Item	$ 170,105.00	24%	$ 40,825
Total Fringe (Program Budget Line 2)			

Total Personnel*	**$ 170,105**

* Should align with Personnel Costs row in Program Budget

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Ongoing training			$ 1,513.38
Total Training and Professional Development (Program Budget Line 3)			**$ 1,513.38**

Provide a description of each Training and Professional Development line item included in the table above:

Based on the experience of the Member organizations, $546/year/FTE has been allocated to support the administration of training for CP employees as well as ongoing training and professional development. The above budget line represents approximately 3 FTEs (approximately 34 FTE months).

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
Executive Director	350	4.5	0.535	$ 842.63
LTSS Program Manager	350	2.1	0.535	$ 393.23
LTSS Care Coordinators	70	28	0.535	$ 1,048.60
			Total Mileage	$ 2,284.45

Travel Expense Description	Cost
Total Mileage	$ 2,284.45
Parking and tolls	$ 1,281.55
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ 3,566.00**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

In the Prep Budget Period, the LTSS Program Manager and Executive Director will travel to meetings with ACOs and MCOs leaders across across Boston and Eastern Massachusetts. They will also attend MassHealth meetings. In addition, the LTSS Care Coordinators will be hired at each of the 7 organizations and will be expected to travel prior to the program start for trainings, meetings with ACOs and other network providers. Travel expenses include mileage and parking costs.

Row 5 - Equipment

Description of Equipment	Unit Cost	#units or FTEs	Cost
Total Equipment (Program Budget Line 5)			

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost

	A	B	C	D
153	Office supplies, printing, copying, postage			$ 1,297.19
154				
155				
156				
157	**Total Supplies (Program Budget Line 6)**			**$ 1,297.19**

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Based on the experience of the Member organizations existing LTSS care coordination programs, $39/month/FTE has been allocated for supplies including office supplies, printing, copying, and postage. This is for approximately 3 FTEs.

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
		Total Software Licensing (Program Budget Line 8)	

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
		Total Telecommunications (Program Budget Line 9)	

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Row 10 - Occupancy

	Occupancy Expense	Total SqFt	Cost/SqFT	Cost
310	Rent			$ 6,494.50
311	Utilities			$ 1,558.68
312	Repair and Maintenance			$ -
313				$ -
314				$ -
315	**Total Occupancy (Program Budget Line 10)**			**$ 8,053.18**

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

This funding will support 8 different locations including work space for 7 care teams each containing 2 LTSS Care Coordinators and a space for the management team that includes the Executive Director and the LTSS Program Manager. The space will provide flexible work stations for care coordinators who spend the majority of their time in the community but need a place to dock for supervision, documentation, copying, printing, etc. Each of the 8 locations is allocated $811.81 in the prep budget period for rent and $194.84 in the prep budget period for utilities. Each of the 8 locations will provide space for 2 employees (7 locations will provide space for 2 LTSS Care Coordinators and 1 location will provide space for the Executive Director and LTSS Program Manager). This is approximately $200/FTE/month for rent and $48.75/FTE/month for utilities. The members' experience is that these are adequate amounts.

We commit to not allocating more than $25/ square foot for rent.

Row 11 - Other

	Other Direct Expense Description	Cost
349		
350		
351		
352		
353		
354		
355	**Total Other Direct Costs (Program Budget Line 11)**	
356		

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

	A	B	C	D	E	F	G	H	I	J	K	L
387	**Indirect Cost/Administrative Overhead**	**Rate**	**Total Indirect Cost**									
388	**Total Indirect Cost/Administrative Overhead**	**12.1%**	**$**	**27,173.00**								
389												
390												
391												
392	***Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:***											
393												
394	This administration line includes all non-direct administrative functions to support the program including human											
395	resources at each Member organization for recruitment, HR management and training, accounts payable, payroll, IT											
396	maintenance and support, and building/location/real estate functions. It has been an appropriate amount based on											
397	experience.											
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Community Partner Infrastructure Budget Report

Boston LTSS Community Partners

	Infrastructure Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
	PMPM Infrastructure Rate		$ 75.00	$ 49.72	$ 43.28	$ 36.40	$ 29.34	
	Engaged Enrollees		1,296	1,296	1,624	1,624	1,624	
	Estimated Infrastructure Funds		$ 680,558	$ 773,424	$ 843,311	$ 709,254	$ 571,690	**$ 3,578,237**
	At- Risk Withhold Rate			25%	44%	63%	81%	
	Withhold			$ 193,356	$ 371,057	$ 446,830	$ 463,069	**$ 1,474,312**
	TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 680,558	$ 580,068	$ 472,254	$ 262,424	$ 108,621	**$ 2,553,925**
	Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
	Technology							
1	**IT Staffing including Fringe**	$ 15,634	$ 12,525	$ 25,089	$ 25,493	$ 25,904	$ 26,324	**$ 130,969**
2	**Development Adaptation of EHR and/or Care Management System**	$ -	$ 21,702	$ 12,000	$ 12,000	$ 12,000	$ 12,000	**$ 69,702**
3	**Technology for Service Delivery**	$ -	$ 13,597	$ 21,922	$ 20,605	$ 20,593	$ 20,826	**$ 97,543**
4	**Other Technology Expenses**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Technology	$ 15,634	$ 47,824	$ 59,011	$ 58,098	$ 58,497	$ 59,150	**$ 298,213**
	Workforce Development							
5	**Workforce Development staffing including Fringe**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
6	**Recruitment Expenses**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
7	**Training Expenses**	$ -	$ 20,000	$ -	$ -	$ -	$ -	**$ 20,000**
8	**Retention Expenses**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Workforce Development	$ -	$ 20,000	$ -	$ -	$ -	$ -	**$ 20,000**
	Business Start Up Costs							
9	**Office Equipment (PBP & BP1 only)**	$ -	$ -					**$ -**
10	**Office Furniture (PBP & BP1 only)**	$ -	$ -					**$ -**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**	$ 252,530	$ 413,958	$ 313,686	$ 149,536			**$ 1,129,710**
	Total Business Start Up Costs	$ 252,530	$ 413,958	$ 313,686	$ 149,536	$ -	$ -	**$ 1,129,710**
	Operational Infrastructure							
12	**Operation Staffing including Fringe**	$ 160,022	$ 64,662	$ 93,480	$ 95,194	$ 97,577	$ 100,129	**$ 611,064**
13	**Other Operational Expenses**	$ 21,300	$ 19,222	$ 19,367	$ 19,516	$ 19,669	$ 19,827	**$ 118,901**
	Total Operational Infrastructure	$ 181,322	$ 83,884	$ 112,847	$ 114,709	$ 117,246	$ 119,956	**$ 729,965**
14	**Indirect Cost/Administrative Overhead Rate**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	TOTAL INVESTMENTS	**$ 449,486**	**$ 565,666**	**$ 485,544**	**$ 322,343**	**$ 175,743**	**$ 179,106**	$ 2,177,889

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Tier 2 support	$ 57,500.00	1	3.3	$ 15,634
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	1		$ 15,634
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 15,634**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Learning, testing, and training of LTSS Care Coordinators on use of new Care Coordination and Information Technology system. Preparation to train users and handle HelpDesk type questions about the systems. We will hire this person as soon as funding allows in the month of February, 2018.

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost

	A	B	C	D	E	F	G
34							
35							
36							
37							
38							
39	**Total Development and Adaptation of EHR and Care**						
40	**Management System**						
41	**(Infrastructure Budget Line 2)**						
42							
43	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract***						
44	***and how the costs were determined:***						
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58	**Row 3 - Technology for Service Delivery**						
59	**Description of Expense**	**Cost**					
60							
61							
62							
63							
64							
65							
66	**Total Technology for Service Delivery**						
67	**(Infrastructure Budget Line 3)**						

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Row 4 - Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses (Infrastructure Budget Line 4)	

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 6 - Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses (Infrastructure Budget Line 6)	

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Row 7 - Training Expenses

	A	B	C	D	E	F	G
169	Description of Expense	Cost					
170							
171							
172							
173							
174							
175							
176	**Total Training Expenses**						
177	**(Infrastructure Budget Line 7)**						
178							
179	***Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of***						
180	***the CP's contract and how the costs were determined:***						
181							
182							
183							
184							
185							
186							
187							
188							
189							
190							
191							
192							
193							
194							
195							
196	**Row 8 - Retention Expenses**						
197	Description of Expense	Cost					
198							
199							
200							
201							
202							

	A	B	C	D	E	F	G
203							
204	**Total Retention Expenses**						
205	**(Infrastructure Budget Line 8)**						
206							
207	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of***						
208	***the CP's contract and how the costs were determined:***						
209							
210							
211							
212							
213							
214							
215							
216							
217							
218							
219							
220							
221							
222							
223	**Community Partner <u>Infrastructure</u> Budget Report - Business Start Up Costs - Prep Budget Period**						
224							
225	**Row 9 - Office Equipment**						
226	Description of Expense	Cost					
227							
228							
229							
230							
231							
232							
233	**Total Office Equipment**						
234	**(Infrastructure Budget Line 9)**						

Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were determined:

Row 10 - Office Furniture

Description of Expense	Cost
Total Office Furniture (Infrastructure Budget Line 10)	

Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Director of Operations	$ 95,000.00	0.8	3.4	$ 21,381.21
Director of Quality and Analytics	$ 95,000.00	0.8	3.4	$ 21,381.21
Project Manager	$ 75,000.00	0.8	5.5	$ 27,500.00
VP - Controller	$ 128,000.00	0.14	5.5	$ 8,213.33
Budget Director	$ 85,000.00	0.07	5.5	$ 2,727.08
Director of Accounts Receivable	$ 91,250.00	0.105	5.5	$ 4,391.41
Business Analyst	$ 75,000.00	0.42	5.5	$ 14,437.50
Senior Accountant	$ 70,000.00	0.42	5.5	$ 13,475.00
Billing Coordinator	$ 40,000.00	0.7	5.5	$ 12,833.33
Manager of Business Systems	$ 84,482.00	0.07	5.5	$ 2,710.46
	Total Salary	4.325		$ 129,050.53
	Fringe rate	24.0%	Total Fringe	$ 30,972.13
			Total Program Staffing including Fringe (Infrastructure Budget Line 12)	**$ 160,022.66**

Row 13 - Other Operational Expenses

Description of Expense	Cost
Financial software (setup, mgmt, license)	$ 6,300.00
Design of logo and brand ($100/hour * 15 hours)	$ 1,500.00
Website development and hosting	$ 12,500.00
Printing of a brochure for ACOs (500@ $2 each)	$ 1,000.00
Total Other Operational Expenses (Infrastructure Budget Line 13)	**$ 21,300.00**

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

As part of standing up the financial system for the program, it will be necessary to license, set up, and expand the users of the software for all the payors and payees. This is more financial set up and management than IT.

Marketing funds will be used to develop a website, logo and basic promotional materials for Enrollees and providers.

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)		

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

BLTSSCP is choosing not to include an administrative overhead rate in the infrastructure budget for two reasons:
1) BLTSSCP is the management company for administering the LTSS CP program on behalf of 7 Consortium Entities. We consider BLTSSCP itself as administrative overhead for the LTSS CP program.
2) In the infrastructure budget, there are costs that are not within the BLTSSCP organization itself. For example, financial services are contracted out to Bay Cove and IT services are contracted out to Vinfen. Our assumption is that the administrative overhead rate within the program budget will cover administration of those additional services.

Community Partner Infrastructure Allocation Worksheet

	Boston LTSS Community Partners						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL FUNDS AVAILABLE	$ 450,000	$ 680,558	$ 580,068	$ 472,254	$ 262,424	$ 108,621	$ 2,553,925
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
BLTSSCP	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bay Cove Human Services							
Boston Center for Independent Living							
Boston Senior Home Care							
Justice Resource Institute	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Mystic Valley Elder Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Somerville Cambridge Elder Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Vinfen	$ 15,634	$ 47,824	$ 59,011	$ 58,098	$ 58,497	$ 59,150	$ 298,213
Total Technology	$ 15,634	$ 47,824	$ 59,011	$ 58,098	$ 58,497	$ 59,150	$ 298,213
Workforce Development							$ -
BLTSSCP	$ -	$ 20,000	$ -	$ -	$ -	$ -	$ 20,000
Bay Cove Human Services							
Boston Center for Independent Living							
Boston Senior Home Care							
Justice Resource Institute	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Mystic Valley Elder Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Somerville Cambridge Elder Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Vinfen	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ -	$ 20,000	$ -	$ -	$ -	$ -	$ 20,000
Business Start Up Costs							$ -
BLTSSCP	$ 84,530	$ 368,943	$ 313,686	$ 149,536	$ -	$ -	$ 916,695
Bay Cove Human Services	$ 24,000	$ 7,977					$ 31,977
Boston Center for Independent Living	$ 24,000	$ 5,271					$ 29,271
Boston Senior Home Care	$ 24,000	$ 5,271					$ 29,271
Justice Resource Institute	$ 24,000	$ 7,977	$ -	$ -	$ -	$ -	$ 31,977
Mystic Valley Elder Services	$ 24,000	$ 5,271	$ -	$ -	$ -	$ -	$ 29,271
Somerville Cambridge Elder Services	$ 24,000	$ 5,271	$ -	$ -	$ -	$ -	$ 29,271
Vinfen	$ 24,000	$ 7,977	$ -	$ -	$ -	$ -	$ 31,977
Business Start Up Costs	$ 252,530	$ 413,958	$ 313,686	$ 149,536	$ -	$ -	$ 1,129,710
Operational Infrastructure							$ -
BLTSSCP	$ 98,876	$ 52,393	$ 80,728	$ 81,949	$ 83,830	$ 85,869	$ 483,646
Bay Cove Human Services	$ 82,446	$ 31,491	$ 32,119	$ 32,760	$ 33,416	$ 34,087	
Boston Center for Independent Living							
Boston Senior Home Care							
Justice Resource Institute	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Mystic Valley Elder Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Somerville Cambridge Elder Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Vinfen	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ 181,322	$ 83,884	$ 112,847	$ 114,709	$ 117,246	$ 119,956	$ 729,965
TOTAL INVESTMENTS	$ 449,486	$ 565,666	$ 485,544	$ 322,343	$ 175,743	$ 179,106	$ 2,177,888

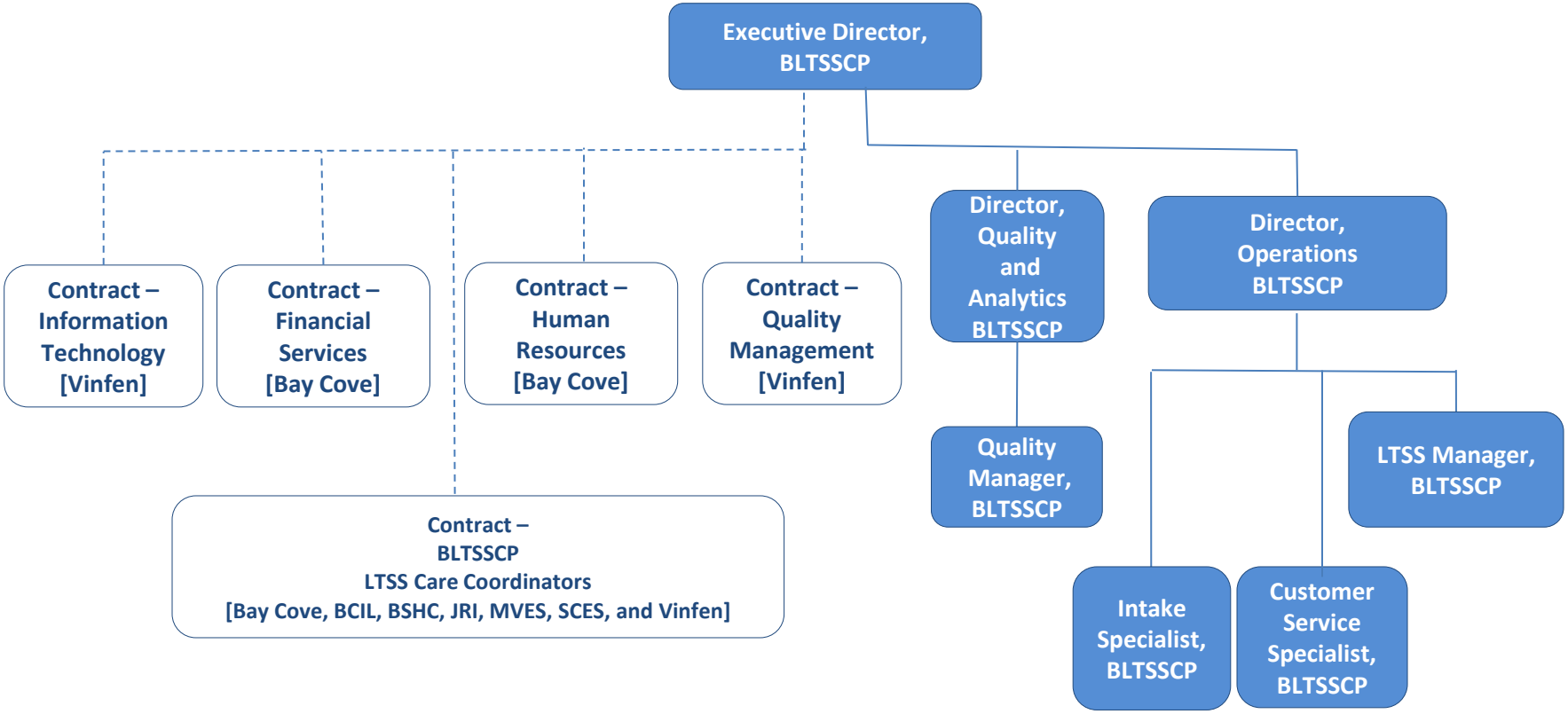
Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	Care Coordination Information System	Procure, configure and implement a Care Coord. Info. System	07/01/17	12/31/18	Release RFP to care coordination system vendors, select and contract with 1 vendor, develop requirements for initial configuration of system	Contract with care coordination sytem vendor, implementation plan agreed to			Finalize design for care coordination platform	Design documents showing how care coordination system will be configured		
Technology												
Technology												
Technology												
Workforce Development	Development of comprehensive training curriculum and plan for delivering curriculum	Develop 13 modules of training curriculum and put in format for CP employees	07/01/17	05/31/18	Five of the 13 modules developed and formatted for CP employees; training implementation plan developed	Sampling of the completed modules, implementation plan document			All 13 modules developed and formatted for CP employees	Sampling of the 13 developed modules		
Workforce Development	Fill key EMCP management team and care team leader positions	Key BLTSSCP Management positions, and sevenLTSS Care Coodinator positions filled	10/01/17	05/31/18	Key BLTSSCP management team positions and member organization positions are filled	BLTSSCP Executive Director and Project Manager hired			Additional key BLTSSCP management team positions and care team leaders are filled	7 LTSS Care Coordinators hired/appointed; BLTSSCP Director of Operations and BLTSSCP Dir. of Quality and Analytics hired		
Workforce Development												
Workforce Development												
Business Start Up Costs	Care Coordination contracts	Develop contracts with each of the 7 organizations providing local LTSS CP care teams	07/01/17	04/01/18	Contracts developed with each of the 7 organizations providing LTSS CP care team services that include program specifications, payment terms	Executed contracts						
Business Start Up Costs	Financial systems	Develop key financial systems including chart of accounts, financial report requirements, configuration of accounting software.	09/01/17	05/31/18	Business Analyst hired, chart of accounts established, financial reporting specifications developed, uniform fiscal reporting procedures established.	Business Analyst hired, chart of accounts established, sample financial reporting specifications			Hire and train Billing Coordinator, test accounting software and fiscal reporting process. Complete documentation of billing procedures. Develop and document payment procedures to partner entities.	Billing Coordinator hired, sample documentation of billing and payment procedures		
Business Start Up Costs	ACO/MCO contracting	Execute agreements with 10 ACOs and 2 MCOs	07/01/17	04/30/18	Model agreement developed and shared with ACO/MCOs inclusive of proposed documented processes	Draft of model ACO/MCO agreement inclusive of proposed documented processes under consideration			Agreements executed with 10 ACOs and 2 MCOs	Executed agreements		
Business Start Up Costs												
Operational Infrastructure	Development of Documented Processes	Development of 11 Documented Processes for internal planning and ACO/MCO contracting	07/01/17	04/30/18	Drafts of Documented Processes developed and under consideration	Draft of Documented Processes developed and under consideration						
Operational Infrastructure	Referral/assignment process	Develop process for receiving referrals from MassHealth, ACOs and MCOs and distributing those to care coordination organizations	07/01/17	05/31/18	Process developed and data specifications for receipt of referrals	Documented workflows			Process tested with three ACO/MCOs	Documentation of test		
Operational Infrastructure												
Operational Infrastructure												

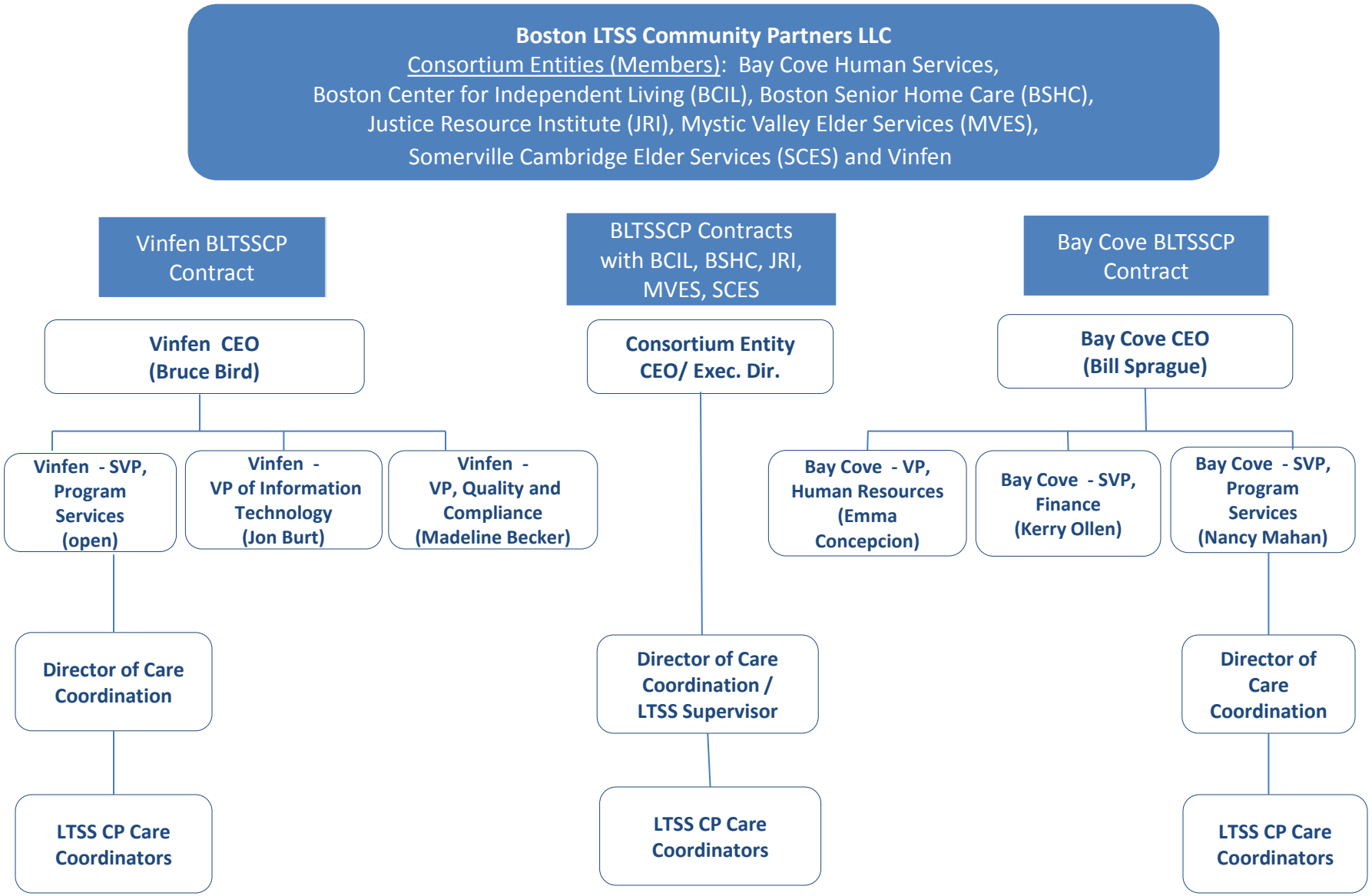
Attachment A – BLTSSCP Organizational Chart

Boston LTSS Community Partners LLC

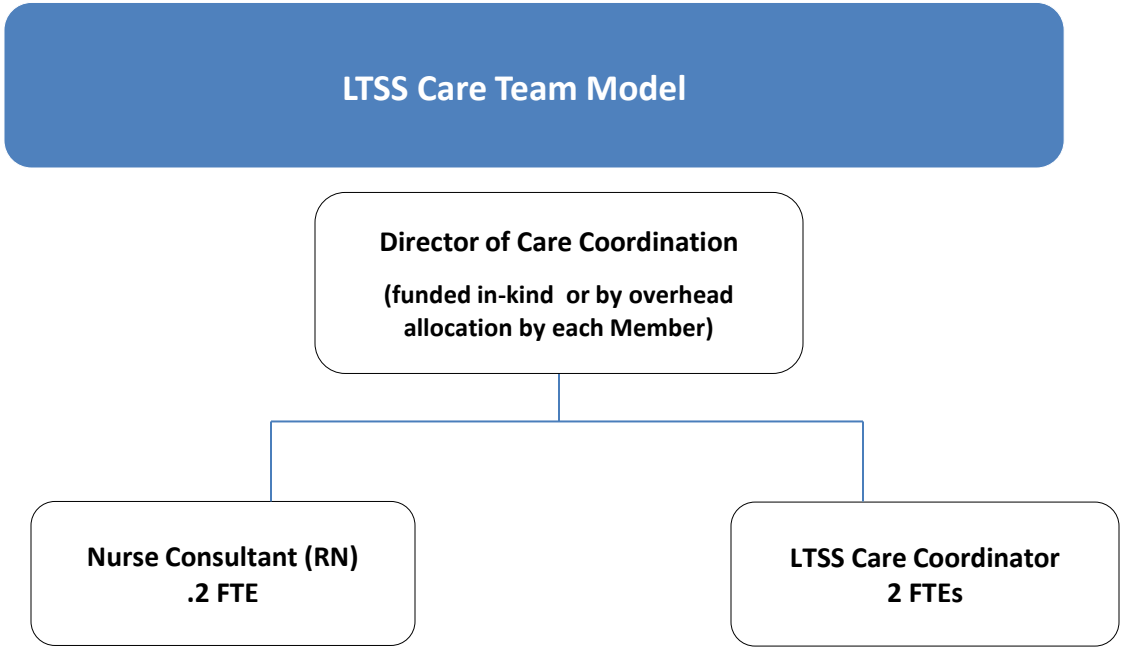
Consortium Entities (Members): Bay Cove Human Services, Boston Center for Independent Living (BCIL), Boston Senior Home Care (BSHC), Justice Resource Institute (JRI), Mystic Valley Elder Services (MVES), Somerville Cambridge Elder Services (SCES), and Vinfen



Attachment B – BLTSSCP Organizational Chart of Contracted Services



Attachment C – Care Team Organizational Chart



7.5 E Personnel and Staffing

Provide proposed staffing plan to perform the Contractor Responsibilities set forth in Attachment A, including fully implementing required scope of CP Supports and administrative aspects of Contract

The Members of BLTSSCP have extensive experience developing new programs that must be launched and staffed within short time frames. For example, in 2009, Bay Cove and Vinfen each implemented the newly awarded DMH CBFS programs on time, re-designing jobs of existing employees and hiring hundreds of new staff. Boston Senior Home Care (BSHC), Boston Center for Independent Living (BCIL), Mystic Valley Elder Services (MVES) and Somerville Cambridge Elder Services (SCES) staffed up quickly to meet the needs of the One Care plans Long Terms Services and Supports Coordinator (LTSC).

Each BLTSSCP Member will provide LTSS Care Coordination to Enrollees and will employ an outreach model where each LTSS Care Coordinator has an office as a home base, but will accomplish their work outside the limits of an office: in an Enrollee's home or preferred location in the community; in some cases on the street; very often at locations of other community support and social services providers; or in ACO/MCO medical and behavioral health clinics. Decisions on care team locations and the number of Enrollees assigned to each team will be based on several factors: the number of ACO/MCO referrals, the needs of the Enrollee populations, the expertise of each Member in serving LTSS sub-populations, and where Enrollees live. Prior to the start of the program, BLTSSCP Members will agree to an algorithm for assigning the Enrollees to a particular Member for LTSS Care Coordination. The assignment algorithm will be based on the needs of the Enrollee, the expertise of the Member in serving certain populations, existing relationship between the Enrollee and a Member organization and geography.

As discussed in **Section 7.2.B**, key administrative functions will be performed by a small BLTSSCP central management team or delegated to a Member to perform.

1. Provide organizational chart that identifies personnel, senior managers, and other staff by title to be assigned to accomplish Contractor Responsibilities described in Attachment A

See **Attachment 4:** BLTSSCP organizational chart and **Attachment 5:** BLTSSCP care team organizational chart.

2. Sample staffing model for number of Enrollees in each Service Area, including the number of FTEs for supervision, administration, Care Management/Care Coordination positions

BLTSSCP has developed a care team model that will be adapted by each Member and support caseloads of between 100 and 200 Enrollees. See **Attachment 6:** BLTSSCP care team organizational chart for care team composition. Each team will consist of an LTSS Care Coordinator with a caseload of 80 Enrollees in Y1, 90 Enrollees in Y2, and 100 Enrollees in Y3-Y5, 10% of an RN Consultant and 25% of an LTSS supervisor for the LTSS Care Coordinators. Please see **Attachment 7** for Care Team job descriptions. The table below summarizes the number of FTEs for each position that will be required when BLTSSCP Enrollment is at

Capacity (1,624 Enrollees). Staffing will be adjusted based on number of Enrollees as care teams are starting up.

Position	Number of FTEs [assumes 1,624 Enrollees]
LTSS Supervisor (Director of Care Coordination) .25 FTE appointed in each Member)	4
LTSS Care Coordinator	16
RN Consultant (.1 for every 100 Enrollees)	1.6
Total	**21.6**

For administrative functions, BLTSSCP will employ a central management team to provide EOHHS contract oversight and manage central operations such as intake of Enrollees, referral to care teams, grievances, marketing, ACO/MCO contract development, and management of LTSS Care Coordination contracts with Member organizations. The BLTSSCP management team will include an Executive Director, Director of Quality and Analytics, Director of Operations, LTSS Manager, Customer Service Specialist and Intake Specialist. (Please reference **Attachment 2** in Section 7.2B for job descriptions of these central management positions). The central management team will contract with Bay Cove for financial services and HR, and with Vinfen for IT services, website and quality management. The staff positions required for those contracted services are detailed in **Attachment C**: Budget Narrative and job descriptions are detailed in **Attachment 7**.

3. Describe recruitment plans, including timelines to recruit staff for any personnel positions not currently filled, and job descriptions and qualifications for each personnel position.

Each BLTSSCP Member has a professional HR Department responsible for meeting the recruitment needs across service types while promoting staff retention. The seven Members have a combined workforce of more than 8,000 employees. Each has extensive experience at both "staffing up" new programs and new service types, and sustaining a capable, well trained and engaged mobile workforce.

As soon as BLTSSCP learns of its LTSS CP award, the BLTSSCP will launch both internal and external recruitment plans in order to fill key management positions such as Executive Director and Deputy Director. With job descriptions developed and finalized in advance (see attached), recruitment of these key positions will begin in early November 2017. In January each Member will allocate part of an existing staff person to serve as Director of Care Coordination for the LTSS CP. In mid-March, each CE will hire an LTSS Care Coordinator. DSRIP funds will be used to subsidize the LTSS Care Coordinators while ramping up to full caseloads. The Directors of Care Coordination, approximately a .1FTE to .2FTE position in each Member, will be self-funded by each Member. The following is the timeline for filling key positions:

Recruiting	Start date	Key Positions
Sep 2017- Mar 2018	Jan 2017- Mar 2018	BLTSSCP Executive Director, BLTSSCP Project Manager, BLTSSCP IT Systems Administrator,

		BLTSSCP Financial Analyst, Director of Care Coordination (appointed / allocated / hired by each Member)
Dec 2017 – Apr 2018	Feb 2018- Apr 2018	BLTSSCP LTSS Manager, BLTSSCP Director of Operations, BLTSSCP Director of Quality and Analytics, BLTSSCP NP and Psychiatrist, LTSS Supervisors (appointed / allocated), CCIT Systems Support
Mar 2018 – Jun 2018	May 2018- Jun 2018	LTSS Care Coordinators (1 FTE for each Consortium Entity), Nurse Consultant allocated as needed, IT User Support Specialist, BLTSSCP Intake Specialist, BLTSSCP Customer Service Specialist

Our recruitment campaigns will include widespread advertising; outreach to career fairs, trade organizations, community based organizations and cultural centers; college and certification program outreach; and by sourcing through online resume mining. Our campaigns will also benefit from sourcing internally. Each Member promotes a strong employee referral program as well as a commitment to promoting from within. Each has demonstrated experience in launching new programs through the promotion of qualified candidates and expects to make the most of this practice to staff our CP care teams. This multi-pronged approach to recruitment will yield both internal and external candidates and meet timelines. Members operate in time-sensitive processing of interview candidates to quickly complete screenings and hiring, expediting drug testing, background and reference checks for selected candidates. Our goal will be to have official offers made within 4 weeks of initial screening, which include program level interviews and drug testing, background and references checks. Through multi-faceted recruitment approaches and expedited hiring processes, we will ensure sufficient staff are hired, oriented and trained so that they can effectively begin outreach / engagement activities on June 1, 2018.

4. Describe plan to recruit and hire staff from cultural/linguistic communities served

The Members of BLTSSCP are committed to hiring staff that are reflective of those we serve. To exemplify this principle, in April 2017 Vinfen launched a new recruitment and retention campaign: "My Job, My Community, My Vinfen." This tagline was selected not by Vinfen leadership, but by direct care staff and front line managers. Extensive focus group review further reinforces that our employees identify strongly with the programs, clients, and communities with which they work. BLTSSCP will target its advertising specific to the geographic and demographic communities our Community Partner services will reach in order to meet our staffing needs.

As noted above, each Member will use a variety of strategies and sources to recruit and on-board personnel needed, including a combination of internet advertising, social media, print media, billboards, and advertisements on public transit. As in past campaigns, Members will: use newspapers, websites, and radio spots that reach ethnic and cultural communities of those we serve; attend Boston's Annual Diversity Employment Day Career Fair as well as Boston's Bilingual and Diversity Job Fair; advertise in print media such as Bay Windows; and outreach to cultural organizations such as the Haitian Multi-Service Center and to colleges and universities

with diverse student populations. Through these efforts, we intend to continue our practices of hiring staff who are bilingual and bicultural to match the needs of targeted populations.

5. Describe proposed training, orientation plans and modules for staff

As noted earlier, each Member of BLTSSCP has a centralized Human Resources Department serving a combined workforce of more than 8,000 employees. Each Member also has a robust training system which starts with weekly new employee orientation. New employee orientations are comprehensive and inclusive of: agency history and mission, organizational structure, overview of populations served, agency policies and procedures, employee relations, professional ethics, diversity, communication systems, culture of caring, and training and advancement opportunities. Mandatory trainings such Compliance, Universal Precautions, and Sexual Harassment are included in this initial new employee orientation.

After completing new hire orientation, employees begin their program-specific orientation and training. While each Member's Training department is staffed with full time trainers, each also benefits from a cadre of Subject Matter Experts - operational staff within each service type that offer specialized training complimentary to the training department courses. For our LTSS Care Coordinators and RN Consultants, program specific modules will include the following required trainings:

- Overview of the LTSS CP program and approach
- Overview of LTSS populations including those with brain injuries, cognitive impairments, physical disabilities, autism and intellectual/developmental disabilities;
- LTSS Care Plan development process and implementation, including Care Team development and the principles of Self Determination and Community First;
- Overview of MassHealth state plan LTSS services and eligibility criteria, as well as choice counseling and person centered planning processes(using EOHHS approved curriculum);
- Orientation to roles/responsibilities of state/community/municipal agencies and organizations
- Overview of independent living movement/recoveryprinciples(accessibility/ accommodations;
- Orientation to local resources and community mapping techniques
- Orientation to national research and advances
- Orientation to health care integration strategies such as Population Health Management
- Orientation to Enrollee Engagement strategies including Motivational Interviewing, stage of change and harm reduction techniques;
- Orientation to Health and Wellness Principles and Coaching tools
- Orientation to available human, legal, civil rights, community, LTSS, SDH, mental health, community health, SUD services and other resources
- Knowledge of empowerment and self-advocacy techniques
- Cultural competencies training including cultural, religious, ethnic, disability, and gender awareness and resources;
- Enrollee Rights and Protections;
- Conflict of interest and ethics policies, and conflict of interest mitigation strategies
- Orientation to Care Coordination Information Technology (CCIT) system.

6. Describe staff retention strategy

BLTSSCP Members have robust strategies for effectively promoting retention of talented personnel. The Members' collective experience validates that staff retention is highly correlated with engagement in Mission, as employees seek to make a meaningful contribution, to make a difference, and to positively impact people served. Leadership teams in turn value their employees and the day to day contributions they make to those served. Retention strategies employed by each Member promote such cultures of dignity and respect. They promote cultures of flexibility, of team work, and they embrace diversity. They enable employees to attend to both their professional responsibilities and their commitment to home and family. And they invite ongoing dialogue between management and direct care staff through a variety of avenues including staff satisfaction and engagement surveys, direct care roundtables and town meetings with the CEO, suggestion boxes, and the promotion of an open door policy. Formal retention strategies employed by each Member are outlined below:

- Competitive wages within the Human Services Industry: Each Member continually assesses how its wages compare to those of its competitors. Through careful financial stewardship, each has been able to remain competitive within the industry.

- Outstanding Employee Benefits: Member employees regularly cite generous benefits as something important to them and as something that factors into their decision to maintain their tenure with their employer. Each Member continuously assesses and adjusts its benefits program to offer a package that supports an employee's personal and family needs, and may include any combination of: health insurance, dental insurance, vision plan; retirement plan; 403(b) Tax-deferred annuity plan; vacation, sick, holiday and personal time; life insurance; Long-term Disability Insurance; Commuter Benefits; Employee Assistance Program; Healthcare and Dependent Care Spending Plans; Professional Development and Educational Assistance; Compassionate Relief and Natural Disaster Programs.

- Training / Staff Development: Each Member promotes and embodies the principles and practices fundamental to Learning Organizations. Each is committed to doing their part to promote the development of our workforces, personally and professionally. Whether through training refresher or recertification courses or newly developed classes to promote evidence based practices, the Members' collective workforce is continually receiving the information they need to perform most effectively and advance in their careers. New Managers are offered training specific to the administrative functions of their new role while Basic and Advanced Supervisory Skill Trainings offer modules specific to becoming an effective supervisor; employee coaching, conflict resolution; diversity in the workplace; interviewing and hiring; and tough issues. All Members offer Employees the opportunity to attend external trainings, workshops and CEU's (as applicable) to promote their professional development.

- Employee Recognition: Each Member promotes employee recognition in a variety of ways. As such, it is an intrinsic part of our respective cultures. Sample Employee Recognition programs include: years of service awards, including gifts (monetary or items); quality of care awards; monthly themed awards by job category; peer recognition programs and awards; Employee Newsletters; scholarships; for employees pursuing higher education, fee reimbursements; holiday and seasonal celebrations highlighting staff contributions.

Effective retention strategies are particularly essential for long term growth at a time when the landscape of the human services industry is overwhelmed with challenges, from the consequences of over 3 decades of level funding, to high employee burn out rates, to losing a percentage of the workforce to higher paying opportunities in the for-profit world. With a balanced approach to recruitment and retention, BLTSSCP Members are prepared to meet the scope and capacity of the LTSS Community Partner Program.

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Oct-18	Jan-19	Apr-19
BLTSSCP Contract														
Award	x													
Contract negotations with EOHHS	x	x	x	x										
Agreement on Enrollment Capacity and timing				x	x	x								
Readiness review process with EOHHS				x	x	x	x	x	x					
Staffing and Personnel														
Recruiting and hiring of key employees														
Recruiting for management team	x	x	x	x	x	x	x	x	x	x				
Recruiting for care coordinators/teams					x	x	x	x	x	x	x	x	x	x
Executive Director - start			x	x	x									
Director of Care Coordination at each Member organization			x	x	x									
Director of Operations - start							x	x						
Director of Quality and Analytics - start							x	x						
Assistant Director of Care Coordination - start							x	x						
LTSS Care Coordinators - 1 for each Member organization								x	x					
LTSS Program Manager- start														
Intake Specialist - start								x	x					
IT Project Manager - start							x	x						
IT Systems Administrator - start				x	x									
IT User support - start							x	x						
Financial Analyst - start				x										
Billing Coordinator - start									x					
LTSS Care Coordinators - as needed based on enrollment											x	x	x	x
RN Consultant - appointed / hired									x	x	x	x	x	x
Training														
Development of CP program training curriculum	x	x	x	x	x	x	x							
Implementation of CP program training							x	x			x	x	x	x
Development of CCIT training curriculum								x	x					
Implementation of CCIT training								x	x	x	x	x	x	x
Information Technology														
Care Coordination IT (CCIT)														
Vendor selection and contract negotiation	x	x	x	x	x									
Configuration and development					x	x	x	x	x	x				
Training of LTSS Care Coordination staff									x	x	x	x	x	x
Data warehouse														
Vendor selection and contract negotiation	x	x	x	x	x									
Configuration and development					x	x	x	x						
Training of staff									x	x	x	x	x	

Purchase of equipment for employees														
Laptops and cell phones					x	x	x	x	x	x	x	x	x	x
Development of Financial Systems/ Services														
Configure existing systems for BH CP program			x	x	x	x								
Hire and train Financial Analyst			x	x	x	x	x	x						
Determine feeds required from CCIT to finance systems					x	x	x							
Develop workflows/processes for billing					x	x	x	x	x					
Implement data integration and workflows							x	x	x					
Hire and train Billing Coordinator								x	x					
Marketing														
Develop shared terminolgy for program					x									
Develop marketing plan for ACO/MCOs					x	x								
Develop marketing plans to engage Assigned Enrollees								x	x	x	x			
Develop leave-behind materials for ACO/MCO staff						x	x	x	x	x				
Develop collateral materials for Assigned Enrollees								x	x					
Contracts with Member organizations														
Development of contracts with CEs for key administrative functions			x	x	x	x	x	x						
Development of contracts with CEs for care teams			x	x	x	x	x	x						
Contract management with CEs										x	x	x	x	x
ACO Contract and Relationship Development														
Introductory meetings with ACO/MCOs complete			x	x	x									
Development of prototype project plan for relationship implmentation	x	x	x	x	x									
Development of model contract with ACO/MCOs and sign			x	x	x	x	x	x						
Develop workflows for referrals, assessment/care plan, notification of admissions, care transitions			x	x	x	x	x	x	x	x	x			
Program Operations														
Care team operations														
Develop workflows for all care coordination processes			x	x	x	x	x	x	x	x				
Workflow for clinical escalation within each Member organizations							x	x	x	x				
Identification of meeting and work space for care teams			x	x	x	x	x	x						
Develop LTSS plan Prototype					**x**	**x**	**x**							
Pilot test LTSS plan					**x**	**x**	**x**							
Develop local resource directories					**x**	**x**	**x**	**x**	**x**					
Maintain local resource directories										**x**	x	x	x	x
Intake, referrals and care team assignments														
Develop data elements and file format for receiving ACO referrals				x	x	**x**								
Develop algorithm for referrals to BLTSSCP Care Coordinators					x	**x**	**x**							

Develop process for automated referral input into CCIT							**x**	**x**							
Learning Collaborative															
Develop topics for learning collaboratives							x	x	x	x	x				
Hold first learning collaborative											x				
Consumer Advisory Board (CAB)															
Develop recruitment plan							x	x	x						
Recruit members for CAB									x	x	x				
Hold first CABs												x			
Hold 3 CABs/year														x	
Development of Quality Management programs															
Develop policies and procedures								x	x						
Establish Quality Management Committee Charter and meeting schedule								x	x						
Develop initial Quality Improvement Plan								x	x						
Identify required data elements				x	x										
Build out data elements and alerts in CCIT to capture required data for QI Plan and Performance Measures					x	x	x	x	x						
Colloborate with EOHHS, ACO/MCOs to determine file format for reporting of QI and Performance Measures					x	x	x	x	x						
Produce internal reports for quality monitoring										x	x	x	x	x	
Produce reports for external reporting of quality improvement intitiative data and quality measures										x	x	x	x	x	

Jul-19	Oct-19	Jan-20	Apr-20	Jul-20	Oct-20	Jan-21	Apr-21	Jul-21	Oct-21	Jan-22	Apr-22	Jul-22	Oct-22	
x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
x	x	x	x	x	x	x	x	x	x	x	x	x	x	
x	x	x	x	x	x	x	x	x	x	x	x	x	x	
x	x	x	x	x	x	x	x	x	x	x	x	x	x	
x	x	x	x	x	x	x	x	x	x	x	x	x	x	
x	x	x	x	x	x	x	x	x	x	x	x	x	x	

x	x	x	x	x	x	x	x	x	x	x	x	x	x
x	x	x	x	x	x	x	x	x	x	x	x	x	x
x	x	x	x	x	x	x	x	x	x	x	x	x	x

x	x		x	x	x		x	x	x		x	x	x
x	x	x	x	x	x	x	x	x	x	x	x	x	x
x	x	x	x	x	x	x	x	x	x	x	x	x	x
x	x	x	x	x	x	x	x	x	x	x	x	x	x

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report o
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)
Technology	Care Coordination Information System	Procure, configure and implement a Care Coord. Info. System	07/01/17	12/31/18	Release RFP to care coordination system vendors, select and contract with 1 vendor, develop requirements for initial configuration of system	Contract with care coordination sytem vendor, implementation plan agreed to			Finalize design for care coordination platform
Technology									
Technology									
Workforce Development	Development of comprehensive training curriculum and plan for delivering curriculum	Develop 13 modules of training curriculum and put in format for CP employees	07/01/17	05/31/18	Five of the 13 modules developed and formatted for CP employees; training implementation plan developed	Sampling of the completed modules, implementation plan document			All 13 modules developed and formatted for CP employees
Workforce Development	Fill key EMCP management team and care team leader positions	Key BLTSSCP Management positions, and sevenLTSS Care Coodinator positions filled	10/01/17	05/31/18	Key BLTSSCP management team positions and member organization positions are filled	BLTSSCP Executive Director and Project Manager hired			Additional key BLTSSCP management team positions and care team leaders are filled
Workforce Development									
Workforce Development									
Workforce Development									
Business Start Up Costs	Care Coordination contracts	Develop contracts with each of the 7 organizations providing local LTSS CP care teams	07/01/17	04/01/18	Contracts developed with each of the 7 organizations providing LTSS CP care team services that include program specifications, payment terms	Executed contracts			
Business Start Up Costs	Financial systems	Develop key financial systems including chart of accounts, financial report requirements, configuration of accounting software.	09/01/17	05/31/18	Business Analyst hired, chart of accounts established, financial reporting specifications developed, uniform fiscal reporting procedures established.	Business Analyst hired, chart of accounts established, sample financial reporting specifications			Hire and train Billing Coordinator, test accounting software and fiscal reporting process. Complete documentation of billing procedures. Develop and document payment procedures to partner entities.

Business Start Up Costs	ACO/MCO contracting	Execute agreements with 10 ACOs and 2 MCOs	07/01/17	04/30/18	Model agreement developed and shared with ACO/MCOs inclusive of proposed documented processes	Draft of model ACO/MCO agreement inclusive of proposed documented processes under consideration			Agreements executed with 10 ACOs and 2 MCOs
Business Start Up Costs									
Operational Infrastructure	Development of Documented Processes	Development of 11 Documented Processes for internal planning and ACO/MCO contracting	07/01/17	04/30/18	Drafts of Documented Processes developed and under consideration	Draft of Documented Processes developed and under consideration			Documented Processes finalized with ACOs
Operational Infrastructure	Referral/assignment process	Develop process for receiving referrals from MassHealth, ACOs and MCOs and distributing those to care coordination organizations	07/01/17	05/31/18	Process developed and data specifications for receipt of referrals	Documented workflows			Process tested with three ACO/MCOs
Operational Infrastructure									
Operational Infrastructure									

n PBP - Due to EOHHS August 31, 2018		
Evidence of Success	**Has Milestone**	**If NO, please explain:**
Design documents showing how care coordination system will be configured		
Sampling of the 13 developed modules		
7 LTSS Care Coordinators hired/appointed; BLTSSCP Director of Operations and BLTSSCP Dir. of Quality and Analytics hired		
Billing Coordinator hired, sample documentation of billing and payment procedures		

Executed agreements		
Executed documents		
Documentation of test		

7.2 A Service Areas

Please see **Attachment D** for the Bidder's proposed Service Areas and estimated number of Assigned and Engaged Enrollees that the Bidder will have the capacity to support.

Attachment D: Community Partners Service Area Coverage Form

Please indicate for which Service Areas the Bidder is bidding. Please estminate the number of members the Bidder will have the capacity to support in each Service Area.

Region	Service Area	Bidder Selected Service Areas	Estimated Number of members the Bidder will have the capacity to support within each Service Area
Greater Boston Region	BOSTON - PRIMARY	YES	400
	REVERE	YES	200
	SOMERVILLE	YES	200
	QUINCY	YES	200
Northern Region	BEVERLY	NO	
	GLOUCESTER	NO	
	HAVERHILL	NO	
	LAWRENCE	NO	
	LOWELL	NO	
	LYNN	NO	
	MALDEN	YES	200
	SALEM	NO	
	WOBURN	NO	
Southern Region	ATTLEBORO	NO	
	BARNSTABLE	NO	
	BROCKTON	YES	200
	FALL RIVER	NO	
	FALMOUTH	NO	
	NANTUCKET	NO	
	NEW BEDFORD	NO	
	OAK BLUFFS	NO	
	ORLEANS	NO	
	PLYMOUTH	NO	
	TAUNTON	NO	
	WAREHAM	NO	
Central Region	ATHOL	NO	
	FRAMINGHAM	NO	
	GARDNER-FITCHBURG	NO	
	SOUTHBRIDGE	NO	
	WALTHAM	NO	
	WORCESTER	NO	
Northern Region	BEVERLY	NO	
	GLOUCESTER	NO	
	HAVERHILL	NO	
	LAWRENCE	NO	
	LOWELL	NO	
	LYNN	NO	
	MALDEN	NO	
Western Region	ADAMS	NO	
	GREENFIELD	NO	
	HOLYOKE	NO	
	NORTHAMPTON	NO	
	PITTSFIELD	NO	
	SPRINGFIELD	NO	
	WESTFIELD	NO	

7.2 B Organizational Overview

1. Provide a brief summary of organizational history: date of first incorporation; organizational goals; relevance of Care Management and Care Coordination to mission

Boston LTSS Community Partners (BLTSSCP) is a Limited Liability Corporation formed by Bay Cove Human Services (Bay Cove), Vinfen Corporation (Vinfen), Somerville Cambridge Elder Services (SCES), Mystic Valley Elder Services (MVES), Boston Center for Independent Living (BCIL), Justice Resource Institute (JRI), and Boston Senior Home Care (BSHC) in May 2017 to provide Long Term Services and Supports Community Partner (LTSS CP) Services in the Greater Boston Region and single Service Areas in the Southern and Northern Regions. All Consortium Entities (Members) of BLTSSCP have been anticipating and preparing for the LTSS CP program and the larger MassHealth Delivery Reform initiative which promise to alter the landscape of care and support for people with disabilities in a manner that all Members fully support.

BLTSSCP Members have had decades of experience serving a wide range of people with disabilities, including those with LTSS needs, and representing the varying cultural and linguistic communities of Eastern Massachusetts. The Members have annual operating budgets adding up to nearly $570 million, employ over 8,000 staff and serve over 70,000 people in Eastern Massachusetts. Members have extensive affiliations within a majority of communities in Greater Boston, Malden and Brockton areas including long-standing relationships with schools, faith communities, local municipal organizations, social service organizations, home-based services providers, police and the courts. Each Member has been embedded in the fabric of these communities for decades, and is recognized as the "go to" service provider.

Each Member is committed to care management and coordination for people with LTSS needs and each Member has an impressive experience and history that it brings to the LTSS CP program:

- Bay Cove and Vinfen provide care management for people with Serious Mental Illness through Community Based Flexible Support (CBFS) programs funded by DMH and through the One Care Health Home program funded by Commonwealth Care Alliance. In CBFS, they serve over 3,500 individuals; in the One Care Health Home they serve nearly 400.
- As ASAPs, BSHC, MVES and SCES assist elders and people with disabilities to live in the community with dignity and independence. Through state Home Care program, SCO programs and One Care, LTSS coordination is provided to a range of people with disabilities.
- Bay Cove and Vinfen, as service providers for people with Intellectual/Development Disabilities, are committed to care coordination as an integral part of supporting individuals and coordinate with social service agencies, health care providers, DDS and families.
- JRI's commitment to care management and care coordination has been built through 20 years of successful and innovative programs for DCF as a Commonworks lead, Southeast Regional Resource Center, and Family Networks Lead Agency. JRI is the Community Service Agency (CSA) in four regions of the Commonwealth providing Intensive Care Coordination for youth with serious emotional disturbance (SED) and their families.
- BCIL has been a champion of care coordination for people with disabilities both in its role providing LTSS coordination, PCA services and options counseling as well as in its role advocating for integrated systems of community-based LTSS care in public forums.

2. Describe process of administering Contract: processes and resources for human resources, quality management, compliance, billing, financial accounting, facilities, and legal support

All Members of BLTSSCP have experience managing large, complex government contracts and have built a reputation for excellence in partnering with government agencies to provide human services to a wide range of individuals and families in need. To administer the LTSS CP contract, BLTSSCP will hire a central management team to provide overall contract management for its LTSS CP contract with EOHHS; develop contracts with ACO/MCOs; perform intake and reconciliation functions for referrals and assignment to care teams; and provide oversight on utilization and quality management functions. For some functions such as finance, IT, legal, and quality, BLTSSCP will leverage the expertise and robust departments of its Members, Bay Cove and Vinfen. The central BLTSSCP management team will include an Executive Director, Deputy Director and LTSS CP Program Manager. The central management team will be responsible for ensuring that standards and requirements of the LTSS CP Contract are upheld and provided by each Member. The following services will be contracted to Members:

- Care Teams: Each Member will develop a locally-based care team composed of LTSS Care Coordinators and part-time RN to provide LTSS CP supports to Enrollees and allocate part of an existing staff to serve as Director of Care Coordination and supervise team members.
- Human Resources: Each Member will recruit, hire, and train its own LTSS CP care team employees based on standards developed by BLTSSCP Board of Members and the Executive Director. The organizations have long and successful histories of managing HR functions and are successful in retaining a diverse workforce that provides culturally and linguistically responsive services. Bay Cove will provide HR services to the BLTSSCP management team.
- Legal: Members will offer legal support through in-house or contracted General Counsels.
- Quality Management and Compliance: Each Member has a proven track record of robust quality and compliance systems. Each Member will be responsible for implementing systems and actions to meet Quality and Compliance requirements of federal and state regulations, the standards set by MassHealth for CPs, and the provisions of contracts with ACOs and MCOs. Vinfen's VP of Quality and Compliance of Vinfen, will provide oversight of all these activities, leading the BLTSSS Quality Management Committee with all Members participating.
- Billing and Financial Accounting: Bay Cove will manage the financial services for BLTSSCP. Bay Cove currently manages a financial system with effective cash management, banking, billing, collections and financial reporting for about $105M annually, including contracts with a wide array of public sector funding sources, including DMH, DDS, DPH, MassHealth, MassHealth MCOs, and commercial Behavioral Health payers. Annual audits and Massachusetts Uniform Financial Reports of all Members demonstrate sound financial performance, and strong and effective internal controls in financial management
- Facilities: Members will manage facilities for their care teams; Bay Cove will manage the facility of BLTSSCP's central management team.
- Information Technology: Vinfen will manage BLTSSCP's care coordination information technology (CCIT) system software and data warehouses. Each organization will be responsible for purchasing and managing the IT needs of the LTSS CP care teams. **Section 7.2.E** describes the plans for this CCIT system.

- Marketing Support: While the Executive Director and Deputy Director will do much of the in-person marketing with ACOs/MCOs, and care coordinators will market to assigned Enrollees, Vinfen will provide the back office marketing support.

Of note, Bay Cove and Vinfen are participating as Members along with one other Member to submit a BH CP Bid. If both Bids are successful, the Members will seek administrative efficiencies by centralizing certain functions such as finance, IT management, marketing, and quality in a management company. In addition, two of the central management positions – Executive Director and Deputy Director – will work across the BH and LTSS Community Partner programs.

3. Describe change management processes and capacity and preparation to deliver internal cultural change and systematic change towards integrated care

Members of BLTSSCP have significant experience managing large scale systems changes, and in creating working models with the cultural and practice changes needed. To accomplish systems changes, Members have utilized a number of change management strategies: engagement of staff at all levels, obtaining continuous feedback from persons served and staff, conducting focus groups and training sessions to address cultural and practice model changes, and above all, reviewing and analyzing data on program performance and outcomes to continuously shape the change process and model development. These approaches serve to promote key phases of change management: creating awareness of the mission and business reasons for change; risks if change is not achieved; assessing readiness; ongoing communication of change management map; providing tools for change management; and training of new skills/knowledge needed. Members have learned over the years the importance of managing resistance and acknowledging successes in an ongoing way.

In July of 2009, Bay Cove and Vinfen were each awarded DMH CBFS contracts of significant scale (totaling over 3,500 clients). To implement CBFS, both needed to convert previously-funded DMH programs into the CBFS model, move into new geographies, develop new staff roles, hire hundreds of new employees, re-train existing employees, hire staff from other providers and implement electronic systems to collect and manage data. In addition, Bay Cove, JRI and Vinfen have worked in close partnership with DDS on DDS initiatives such as Employment First and the closing of sheltered workshops, Positive Behavioral Supports, Self Advocacy, and requirements necessary to comply with the CMS Final Rule. These changing landscapes of service provision have required system changes within provider agencies including additions and modifications to staff training, quality systems and reporting, housing, clinical plans, and documentation. Based on collective lessons learned and many successes, we are confident in our ability to manage the requirements of the LTSS CP program and the challenges of working with multiple stakeholders. BLTSSCP can and will facilitate the indicated changes in an effective and timely way.

4. Submit résumés of individuals in Bidder's organization holding the following positions and job descriptions for such positions (does not count towards page limit):

BLTSSCP will recruit and hire a central management team to oversee the LTSS CP Contract with EOHHS. The management team will include the following positions and the individuals that are filling those roles. Please see attached resumes and job descriptions

- Executive Director (Acting): Bruce Bird, Ph.D and Deputy Director (Acting): Bill Sprague
- Chief Financial Officer: Kerry Ollen (SVP and CFO for Bay Cove)

- Director of Care Coordination: This role within each Member organization will supervise each Member's LTSS Care Team.
- Director of Quality Management / Designated Compliance Officer: Madeline Becker, Ph.D. (VP of Quality and Compliance for Vinfen)
- Director of Information Technology: Jon Burt (VP of Information Technology for Vinfen)

7.2 C Governance Structure and Consumer Advisory Board

1a. Describe the responsibilities and functions that each Consortium Entity (Member) will perform under the Contract

BLTSSCP is the Bidder for the LTSS CP program and is comprised of seven Consortium Entities (Members): Bay Cove, Vinfen, Somerville Cambridge Elder Services (SCES), Mystic Valley Elder Services (MVES), Boston Center for Independent Living (BCIL), Justice Resource Institute (JRI), and Boston Senior Home Care (BSHC) which are also its only Members. BLTSSCP is a single legal entity comprised of seven Members, one of the Bidder configurations allowed by MassHealth (see **Section 2.1.A.1** of **Attachment A: Model Contract for Behavioral Health CP**). BLTSSCP is governed by its Members. As described above in **Section 7.2.B.2**, each Member will have the following responsibilities and functions:

- Bay Cove: operate LTSS CP care teams that will serve LTSS CP Enrollees; recruit, hire, train and manage the employees who comprise the LTSS CP care teams; provide financial management, billing and collection services for BLTSSCP
- Vinfen: operate LTSS CP care teams that will serve LTSS CP Enrollees; recruit, hire, train and manage the employees who comprise the LTSS CP care teams; manage the central BLTSSCP Information Technology systems including Care Coordination IT (CCIT) software and data warehouse and exchanges; oversee quality management and compliance; perform marketing support functions such as creation of website and marketing materials
- Somerville Cambridge Elder Services, Mystic Valley Elder Services, Boston Center for Independent Living, Justice Resource Institute, and Boston Senior Home Care: operate LTSS CP care teams that will serve LTSS CP Enrollees; recruit, hire, train and manage the employees who comprise the LTSS CP care teams
- BLTSSCP central management team: oversee LTSS CP Contract with EOHHS; develop relationships and contracts with ACO/MCOs; oversee contracts with Consortium Entities for LTSS CP care teams to ensure quality control; provide intake/enrollment services for MassHealth and ACO referrals for the LTSS CP; develop Consumer Advisory Boards; oversee utilization management

1b. Describe how the Bidder will manage the entity to ensure smooth performance under the Contract:

The Bidder's central management team, reporting to the Members of BLTSSCP, will oversee the contracts with Member for each particular service. For examples, Bay Cove will have a contract with BLTSSCP to provide financial services, billing and collections. The Executive Director of BLTSSCP will ensure Bay Cove is meeting the terms of its contract to provide financial services. Similarly, the Executive Director will develop contracts with each Consortium Entity to establish care teams that provide the LTSS CP coordination services. The BLTSSCP central management team will ensure that the seven Members are implementing LTSS CP coordination teams to the standards required by MassHealth and proposed in this Bid including adequate staffing of and supervision for LTSS coordinators; and the key quality measures specified in **Appendix C: LTSS CP Quality and Accountability**.

1c Describe how the Bidder will allocate DSRIP funding to the entity:

The Bidder has developed a five year LTSS CP program budget that allocates DSRIP funding to each function and each Member. Each Member will receive a monthly per member, per month payment for the core LTSS CP support services that equals 90% of the MassHealth payment as stated in **Appendix F: LTSS Community Partner Payment Rates**. That payment will fund care teams that are locally based and provided by Bay Cove, BSHC, BCIL, JRI, MVES, SCES and Vinfen. The remainder of the MassHealth payment (10%) described in **Appendix F: LTSS Community Partner Payment Rates** will be used to support administrative functions such as IT, finance, quality, contract management, ACO relationship development and consumer advisory boards that are located in the BLTSSCP central management team or sub-contracted to BLTSSCP Members. As described above in **Section 7.2.B.2**, BLTSSCP will contract with two Members - Bay Cove and Vinfen - to perform key functions according to the budget. The BLTSSCP central management team will be supported both through a DSRIP allocation and through the allocation of 10% of the base MassHealth PMPM payment. In addition, as described in **Attachment B: Budget Report and Attachment C: Budget Narrative** each of the seven Members will be provided with supplemental funds of $20,000 in the first year to support the hiring of an LTSS Care Coordinator in advance of having a full caseload. DSRIP funding will also support each Member in the following ways: support for purchase of laptop computers for each LTSS Care Coordinator, purchase of Care Coordination Information Technology (CCIT) license fees, configuration and development of the CCIT.

1d Describe the Bidder's protocols for conflict resolution with the entity:

The Operating Agreement of BLTSSCP defines the processes of the Board of Managers and includes the framework of a more formal conflict resolution process. We will employ a collaborative approach to conflict resolution between Members. We will view conflict as an opportunity to promote greater cohesion, and will invest the time and resources indicated to find a resolution that is acceptable to all.

2. The Bidder shall describe the policy and decision-making process of its Governance Structure, including:

a. The roles of the Bidder, the Bidder's Consortium Entities and Affiliated Partners as part of the decision-making process:

The Bidder is BLTSSCP and its Governance Structure is comprised of seven Members: Bay Cove, Boston Center for Independent Living, Boston Senior Home Care, Justice Resource Institute, Mystic Valley Elder Services, Somerville Cambridge Elder Services, and Vinfen. The BLTSSCP Governance including policy and decision-making processes are detailed in the BLTSSCP Operating Agreement which has been agreed to and adopted by all Members. A unanimous vote of the Founding Members is required to make the following decisions: expansion of the BLTSSCP service area, the addition of a new Member to the BLTSSCP Governance Structure, approval of contractual arrangements with ACO/MCOs that are beyond the MassHealth required elements, hiring an Executive Director to manage BLTSSCP, amending the Operating Agreement, and exit of any of the Founding Members.

b. The Bidder's processes for making decisions on partnership and financial matters:

As it exists today, BLTSSCP is a Consortium of seven Entities. A mutually agreed upon Operating Agreement has been executed between the seven Consortium Entities (Members) which clearly delineates policy and decision making processes. These processes will be implemented when the Governing Board of BLTSSCP is making financial decisions, for example in relation to the contract to be executed with EOHHS and the expense of a Care Coordination System to be implemented within each respective Member organization. Processes to determine policy and decision making will also be implemented when BLTSSCP is executing partnership agreements, for example with ACO/MCOs.

3. The Bidder shall describe its strategy for forming and utilizing a consumer advisory board, as described in Section 2.1 of Attachment A. Such description shall include:

a. The Bidder's plan for forming the consumer advisory board, including procedures to ensure the board is representative of Engaged Enrollees, family Entities, and other caregivers that reflect the diversity of the Service Area(s) for which the Bidder is bidding:

MassHealth's restructuring and reform planning recognizes that multiple stakeholders are essential to delivering key goals of the overall initiative. BLTSSCP affirms that the goals of improving Enrollees' experiences and health outcomes will more readily progress with the learning and input of a robust Consumer Advisory Board (CAB) in place. Therefore, BLTSSCP intends to form and utilize a CAB. The BLTSS Program Manager will be responsible for developing the CAB and holding three meetings each year.

In 2012, Elna Nagasako, MD, PhD, MPH of Community Catalyst authored a paper highlighting national best practices that serve to engage consumers in providing meaningful input in emerging health care delivery services. As Dr. Nagasako contends, CABs are imperative to successful innovations in health care. A robust CAB will inform BLTSSCP's strategies and further promote our mission. As such, BLTSSCP will apply the principles and practices as set forth in her brief [1.]

- Include consumers at the highest possible level of governance and input
- Ensure that the CAB recruitment processes identifies people who are representative of our Enrollees
- Demonstrate commitment to meaningful involvement of the CAB by dedicating sufficient resources
- Promote engagement in CAB by minimizing barriers to meaningful involvement. For example, BLTSSCP will ensure meeting times work for the majority of CAB members, ensure that meetings occur in accessible space near public transportation and provide stipends to support transportation needs. BLTSSCP will also ensure for needed translation supports and stipends to support family care needs
- Ensure that the CAB provide meaningful feedback in assessing and evaluating activities and processes central to BLTSSCP's mission such as access to care, quality of care, outcomes, Enrollee engagement and satisfaction, and the provision of ongoing input in improving member experience and system responsiveness

b. What information or issues that Bidder intends to bring to the consumer advisory board and the processes and procedures the consumer advisory board will follow in considering such matters:

The CAB agenda will include equal parts reporting and listening. BLTSSCP management team, and the seven Consortium Entities will provide reports and updates on topics such as access to and utilization of all services process and outcome measures of quality, Enrollee engagement and satisfaction. In addition, the CAB meeting will serve as a focus group for the BLTSSCP Executive Director and the seven Consortium Entities, eliciting feedback from CAB participants on key topics such as coordination with primary care, Enrollee engagement, and other key questions or practices that BLTSSCP is grappling with.

CAB members will be provided with an agenda one week in advance of each meeting so that they can reflect and provide thoughtful feedback. Leadership staff from each Consortium Entity will participate as active listeners in CAB meetings. Each meeting (three per year) will include a formal review of minutes, considerations given to CAB recommendations and a review of action steps and/or changes made in response to the CAB's recommendations.

c. How recommendations from the consumer advisory board will be incorporated into the Bidder's strategic plan and operations:

Representatives of BLTSSCP will review CAB recommendations with the BLTSSCP Governing Board, BLTSS Executive Director and care team supervisors of each Member. They will consider and prioritize action steps that can respond to and operationalize CAB recommendations. Prioritized action steps, progress and changes made in response to CAB recommendations will be reported on at the next CAB meeting.

7.2 D Experience Serving People

1. All Members comprising the Boston LTSS Community Partners (BLTSSCP) have significant long term and comprehensive experience in supporting people with complex LTSS needs, experience that extends to their families and caregivers as well. For over 40 years, each of the Members has responded to the complexity of needs of individuals coming from institutional care, individuals who benefit from an alternative to institutional care, and individuals living in the community who, due to the intricacies of their needs and situations, are prioritized for services and supports. The Members have proven track records in demonstrating commitment and in effectively supporting people in community settings through integration of care across a wide range of services. The roles of families and caregivers have been fortified and sustained through the development of collaborative teams working on behalf of each person. Please refer to the Table at the end of this section for the numbers of people served.

a. Individuals with complex LTSS and BH Needs

Each Member of BLTSSCP has substantial experience working with people with complex LTSS and BH needs. The co-existing factors of homelessness, SUD, Behavioral Health issues, Psychiatric Disorders, I/DD, complex medical issues and a variety of socioeconomic situations has resulted in provision of services to people representing a cross section of challenges and presenting with a multitude of complex needs.

Bay Cove, JRI and Vinfen provide a comprehensive array of LTSS and BH supports that are designed to meet the individualized needs of those served, including Residential, Individual Supports, Day / Employment, Day Habilitation, Family Support Services to Individuals across focus groups as funded through Department of Developmental Services, Department of Mental Health, Massachusetts Rehabilitation Commission, MassHealth, SHIP, MCB, DESE, DCF, private insurance, as well as private funding. The depth of clinical resources of these Entities, including staff and consultants who are psychiatrists, psychologists, nurses, therapists, licensed social workers, and specialists certified in applied Behavioral Analysis, provides exceptional expertise in designing plans and facilitating collaborations and coordination for people with the most challenging needs.

BCIL operates independent living programs for people of varying physical and developmental disabilities. Supports and services target both LTSS and BH needs and include a PCA program, care transition supports for those leaving Skilled Nursing Facilities, LTSS coordination for One Care Enrollees as well as ILC core services of peer mentoring, advocacy and skills training. MVES, SCES and BSHC provide supports and services for elders with a multitude of care needs including LTSS and BH: nutrition, transportation, home health, care options counseling, group adult foster care, health and wellness, medical escorts and in-home BH counseling. JRI serves children with a wide range of behavioral challenges, and developmental and other disabilities.

b. Individuals with brain injury or cognitive impairments

All Members have extensive knowledge of and experience providing a wide range of supports to people with Brain Injury or cognitive impairments and their families. People served often have complicated care plans due to their injury or impairment and require not only physical care but the development of a comprehensive plan centered on rehabilitation and increased independence

as well as consistent communication with medical and other providers of LTSS, and family members. BSHC, MVES, and SCES work with elders who present with brain injury or cognitive impairments. Through partnerships with multiple agencies and funding sources, elders are connected to a variety of services including Adult Day Health programs specializing in memory loss or dementia, Memory Disorder services, and the Statewide Head Injury Program for veterans. The Hutchinson Agreement and the HCBS Waiver have resulted in targeted funding enabling Bay Cove, BCIL, JRI and Vinfen to provide residential, individual supported living, and enhanced medical and therapeutic services to people with Brain Injury and cognitive impairments up to and including the necessary development of and/or identification of accessible housing possibilities. Members assess needs for individuals and facilitate obtaining adaptive equipment for cognitive supports, durable medical equipment, lifts, accessibility devices, and other environmental modifications.

c. Individuals with physical disabilities

BLTSSCP Members provide a range of services to people who are physically disabled. The ability of all Members to assess for and coordinate the acquisition of durable medical equipment, lifts, accessibility devices, and environmental accommodations enabling individuals with physical disabilities to access their homes, communities, transportation and recreational activities is crucial to meeting the needs of the focus populations. Members also support people who are challenged by a range of visual impairments including blindness and people who are hard of hearing or deaf. BCIL is renowned for their provision of services to people with physical disabilities since it was founded by people with disabilities seeking full integration into society and became the second independent living center in the country. People served by BCIL as well as SCES, MVES and BSHC have a wide range of physical disabilities and are empowered with the practical skills, self-confidence, and self- advocacy skills to take control of their own lives and become active members of their communities.

Bay Cove, JRI and Vinfen have been instrumental in providing the assessment, care coordination, transition planning, and ongoing services required to place hundreds of individuals with LTSS needs throughout the service systems including those transitioning from high-cost nursing care facilities into community-based, integrated services under the auspices of the Rolland Settlement. All services that have been developed have utilized technological and care advances in the field. Nurses and Allied Health Professionals have been integral members of both the teams and the staffing patterns for these supports, providing care coordination with community practitioners, VNA's, hospitals and pharmacy services.

d. Individuals with I/DD, including Autism

Several Members of BLTSSCP have long histories of providing supports to people with I/DD, including Autism, and thereby specialize in serving this population. Since the de-institutionalization of the state facilities in the 1970's, Bay Cove, JRI and Vinfen have been at the forefront in developing group residences and day programs in communities across the Commonwealth. A variety of community based services and supports including residential, day/employment and individual supports have been provided to adults with I/DD, and these CEs operate large Family Support Centers as well as services to children as well as adults, and their family members.

A significant number of the individuals diagnosed as I/DD and eligible for services from the Department of Developmental Services (DDS) have historically also been diagnosed as Autistic. Others with a diagnosis of Autism and a co-existing diagnosis of Serious Mental Illness (SMI) have been eligible for services from the Department of Mental Health. Until 2014 and the enactment of the Autism Omnibus Law, adults with a diagnosis of Autism or Autism Spectrum Disorder but no co morbid diagnosis of Intellectual or Developmental Disability or SMI struggled to find supports. Children with this diagnosis under Developmental Disability were eligible for Family Support Services through DDS. In 2014, DDS was given the responsibility for this adult population. Currently, Bay Cove, JRI and Vinfen all have developed support services for this newly eligible population of adults on the Autism Spectrum.

e. Older Adults up to age 64 with LTSS needs

All BLTSSCP Members provide an array of services to meet the needs of older adults up to age 64 with LTSS needs. BSHC, MVES, and SCES as ASAP's (Aging Service Access Points) are designated by the Commonwealth to provide a single access point for information and services related to publicly funded, community based long term care. Supports for older adults include: care options counseling, care transitions, home modifications, meals on wheels, transportation, chronic disease self-management, group adult foster care, and adult day health. BCIL partners with ASAP's and other community organizations to have timely and worry-free access to services provided across agencies and participates in the Aging Disability Resource Consortium /No Wrong Door Network which enhances collaborations among elder and disability providers to ensure there is 'no wrong door' for an older adult who is looking for supports.

Bay Cove's 'Kit Clark Senior Services' has been a mainstay in the Dorchester community and Greater Boston region for over 40 years, serving a diverse group of participants from a variety of ethnic and cultural backgrounds. Kit Clark offers Adult Day Health, including a specialized dementia program and an ADH program for people experiencing homelessness; day shelter for older people experiencing homelessness; nutrition including Meals on Wheels; in home modifications; a Senior Center, and transportation. Kit Clark's ADH programs offer the coordination of care planning with the participant, family, physicians and other service providers, medical and social services advocacy and support, and ongoing observation and assessment of the participant's functioning.

Bay Cove, BCIL, JRI and Vinfen are dedicated to the philosophy of making provisions for people to 'age in place' and have therefore developed the necessary knowledge and expertise to ensure the appropriateness of services for people who may be experiencing the medical, cognitive, physical and/or psychiatric issues that become more challenging as people age. In addition, the Rolland Settlement afforded the opportunity for these Members to develop intensive medical homes with the purpose of moving medically compromised I/DD people out of Skilled Nursing Facilities and into community settings. Additional RN's, LPN's and CNA's were added to residential staffing to not only provide the day to day care but to also coordinate care with PCP's and other medical practitioners as well as community resources. The support for the residents of these homes has resulted in optimal and person centered care.

f. Children and Youth (ages 3-21) with LTSS needs

Several BLTSSCP Members have extensive experience meeting the LTSS needs of children and youth between the ages of 3 and 21. JRI provides support, residential and educational services for children including those with multiple severe disabilities - severe cognitive impairments, severely limited language/communication skills and severe physical impairments - as well as challenging medical conditions and/or behavioral and mental health issues. JRI is deeply committed to the philosophy and goals of care coordination on behalf of children and provides care coordination programs for DCF as a Commonworks Lead, Southeast Regional Resource Center, and Family Networks Lead Agency, and serves as the CSA for MassHealth in four regions: Boston, the Cape and Islands, Lynn and Lawrence. JRI provides intensive services for children through three residential schools, Intensive Foster Care, STARR (short term assessment programs) and congregate care, a wide range of mental health and physical health services to court involved youth, and operates a center for LGBTQ youth. JRI's Youth Harbors program works with high school aged, homeless youth who are without a supportive family, locating temporary stable housing but continuing to work with the youth to locate permanent housing options. The My Life My Choice Project is a nationally recognized groundbreaking initiative reaching adolescents who are most vulnerable to commercial sexual exploitation.

Through the Money Follows the Person program (MFP) and other waivers, BCIL arranges and provides supports to children over 3 years of age and their families to effectuate a successful transition from skilled nursing facilities, long term rehabilitation facilities, public health hospital or pediatric residential settings. BCIL's Youth Services Division helps youth to set goals, learn to access community services and resources and negotiate unpredictable barriers. Services for youth focus on developing self- advocacy skills and understanding their rights as a person with a disability; peer mentoring and leadership training are components of these services. Youth and their families are provided with information regarding community resources, support options such as personal care attendants, and housing.

Bay Cove and Vinfen provide supports to children/youth with I/DD and their families through Family Support Services. Supports include: education, support groups, assistance in navigating the complexities of service provision, assistance in locating and providing financial supports, in-home support, care coordination, skill building, behavioral interventions / Positive Behavioral Supports, day respite services, and support in finding and maintaining school placements. In addition, transition supports are offered to help families navigate options as a youth transitions out of Children's and 766 services and into Adult Services. Bay Cove also supports children as part of the Department of Elementary and Secondary Education/Department of Developmental Services (DESE/DDS) collaboration, with the goal of providing services to children in the public school system that prevent a more restrictive educational placement and allow children to live at home. Vinfen offers a Teens and Tweens group for youths diagnosed with ASD and has developed a support group for their parents/caregivers.

2. Provide a list of accreditations relevant to Bidder's work with focus population:

- Bay Cove Human Services: Commission on Accreditation of Rehabilitation Facilities (CARF), Medication Administration Program Certification of DPH (MAP), MA DDS Licensing and Certification, MA DMH Licensing and Certification, and MA DPH Licensing and Certification.

- BCIL meets the federal standards as a federally-funded independent living center under Title VII, Chapter 1, Part C of the Rehabilitation Act of 1973, as amended.
- JRI: CARF, Joint Commission accreditation, MA DDS Licensing and Certification. JRI is also a licensed provider for the MA Department of Elementary and Secondary Education, the MA Department of Early Education and Care, the MA Department of Public Health, and the MA Department of Mental Health
- Vinfen: CARF, MAP Certification of DPH, MA DDS Licensing and Certification

Table: Members' experience serving the focus populations by numbers

Row Labels	Bay Cove	BCIL	JRI	MVES	Vinfen	BSHC	SCES	Grand Total
LTSS/BH	**1,139**	**780**	**95**	**766**	**1,883**	**245**	**232**	**5,140**
Greater Boston	1,099	780	40	233	1,276	245	232	3,905
Northern	10		17	533	400			960
Southern	30		38		207			275
Brain Injury/Cognitive Impairment	**898**	**484**	**95**	**54**	**886**			**2,417**
Greater Boston	839	484	40	13	804			2,180
Northern	22		17	41				80
Southern	37		38		82			157
Physical Disabilities	**268**	**2,637**	**14**	**748**	**108**	**820**	**329**	**4,924**
Greater Boston	249	2,637	0	258	86	820	329	4,379
Northern	2		3	490				495
Southern	17		11		22			50
I/DD and Autism	**908**		**55**	**17**	**886**			**1,866**
Greater Boston	846		0	2	804			1,652
Northern	25		17	15				57
Southern	37		38		82			157
Older Adults	**571**	**1,645**	**15**	**705**	**193**	**511**	**313**	**3,953**
Greater Boston	538	1,645	15	226	159	511	313	3,407
Northern	7		0	479				486
Southern	26		0		34			60
Children and Youth	**121**	**321**	**55**		**64**			**561**
Greater Boston	121	321	0		64			506
Northern			17					17
Southern			38					38
Grand Total	**3,905**	**5,867**	**329**	**2,290**	**4,020**	**1,576**	**874**	**18,861**

Beyond the experience listed in this table, several Members have experience in additional geographic areas.

- JRI in Other Massachusetts Regions: LTSS/BH: 220, Brain Injury /Cognitive Impairment: 288, Physical Disabilities: 72, I/DD and Autism: 288, Older Adults: 20, Children/Youth: 29
- JRI in Other states: LTSS/BH: 54, Brain Injury/Cognitive Impairment: 54, Physical Disabilities: 2, I/DD and Autism: 54, Children/Youth: 31
- Vinfen in Other States: LTSS/BH: 144, Brain Injury/Cognitive Impairment: 144, Physical Disabilities: 28, I/DD and Autism: 144, Older Adults: 40

	JRI	Vinfen	Grand Total
LTSS/BH	**274**	**144**	**418**
Non-MA	54	144	198
Other MA	220		220
Brain Injury/Cognitive Impairment	**342**	**144**	**486**
Non-MA	54	144	198
Other MA	288		288
Physical Disabilities	**74**	**28**	**102**
Non-MA	2	28	30
Other MA	72		72
I/DD and Autism	**342**	**144**	**486**
Non-MA	54	144	198
Other MA	288		288
Older Adults	**20**	**40**	**60**
Non-MA	0	40	40
Other MA	20		20
Children and Youth	**60**		**60**
Non-MA	31		31
Other MA	29		29
Grand Total	**1,112**	**500**	**1,612**

7.3 A Relevant experience providing LTSS Supports

1. Developing care plans

BLTSSCP Members develop over 40,000 care plans each year across the state for a range of populations including people with Intellectual and Developmental Disabilities (IDD), Autism Spectrum Disorders (ASD), Acquired Brain Injuries (ABI), Serious Mental Illness (SMI), Physical Disabilities, and chronic medical conditions as well as children and elders with disabilities. Care plans may be called Individual Service Plans, Home Care plans, LTSS plans, Independent Living plans, Day Habilitation Treatment Plans, ADH Plans and Individualized Action Plans. Although the name of the plan varies according to funding source and population, all Members develop care plans that are person-centered and support people with disabilities to achieve their self-determination and independent living goals.

BLTSSCP Members develop care plans that support Individuals to make meaningful decisions about the services and supports they receive including how these services meet their life-goals, where they live, with whom they live, who supports them, what training is critical for a caregiver, and what LTSS and providers are available. Outreach and education regarding the options and choices available to Individuals and families are core components of enabling and encouraging Individuals to make meaningful decisions regarding their supports. All Members have proven experience partnering with Individuals to create care plans reflective of self determination and independent living goals which serve as tools for self advocacy and decision making. The process of outreach and development of care plans integrates the activities delineated in Attachment A: LTSS CP Model Contract, Section 2.3 A. Members use techniques of person-centered planning such as encouraging Individuals to choose their team members, to express their interests and desires, and to build on their strengths and goals. Preliminary meetings to discuss a Vision with the Individual create the framework for all planning.

2. Applying understanding of MassHealth LTSS under M.G.L. c.118E and 130 CMR

Each Member of BLTSSCP has an in-depth understanding and an expertise in applying this understanding of MassHealth LTSS under M.G.L. c118.E and 130 CMR including service eligibility criteria, choice counseling and person-centered care planning. The three ASAPs are MassHealth agents for eligibility determination for LTSS, performing assessments and determining eligibility for nursing facility services, ADH and the Frail Elder Waiver. Through the Home Care program, the three ASAPs (Aging Services Access Point) review LTSS service options and authorize a care plan that may include a variety of LTSS services such as homemaker, personal care, chore services, or Meals on Wheels. Through the Home Care program, ASAPs also assess Individuals for “state plan” or MassHealth LTSS services, and the three ASAPs manage LTSS networks for Senior Care Option (SCO) programs and as a result are intimately familiar not only with LTSS requirements but of also of service providers in their communities.

BCIL is knowledgeable about the range of LTSS and provides choice counseling for people with disabilities. BCIL has special expertise in counseling and assessments for people with physical disabilities and is proficient in the use of assistive technologies and determining eligibility for the PCA program. Vinfen, JRI and Bay Cove have expertise in the specialized LTSS services for people with I/DD, ABI and Autism. As residential providers for people with I/DD and ABI, they

have expertise in developing Individual Service Plans that include LTSS and in ensuring that prescribed supports are accessed. As day habilitation providers, Bay Cove, JRI and Vinfen develop Day Habilitation Treatment Plans that integrate LTSS with health needs.

Some Individuals have used LTSS services for decades, others have LTSS needs that are triggered by a changing life circumstance or change in functioning level that may challenge an Individual's ability to safely remain in or return to the community. Each Member is skilled in assisting individuals through the intricacies and challenges of these transitions. Person Centered Support Planning and the implementation of this Planning consistent with the Vision of an Individual, build the foundation of the plans that are developed.

3. Coordinating care for diverse populations of individuals with disabilities

BLTSSCP Members coordinate care for approximately 40,000 people each year. Section 7.2 D above illustrates the range of populations that Members serve within proposed CP service area. Members provide care coordination and have developed care coordination practices and tools in response to the needs of specific populations. The diversity represented by the individuals has resulted in networking with a multitude of community and health care resources. Familiarity with the range of LTSS resources in the various communities and the impetus to research new and individualized resources as needs and preferences are expressed through a self determined process have led to a wealth of collective and shared knowledge that facilitates the coordination of care. The following are examples of care coordination to specialized populations:

- Bay Cove, JRI and Vinfen coordinate care for people with I/DD, Autism and brain injury, often with co-occurring psychiatric illness and/or physical disabilities. The organizations have developed expertise in the range of specialized programs for the populations including residential, day programs, home-based supports and specialized medical and BH providers.
- JRI operates three specialized, year-round, residential schools for children with high LTSS needs. In that role it has developed relationships with area providers of home-based and specialized medical services. In addition, as a Children's Service Agency (CSA) in four communities JRI coordinates care for children with Serious Emotional Disturbance (SED).
- BCIL provides care coordination and services to individuals confronted with the following challenges: cognitive, mental/emotional, physical, hearing, vision, multiple disabilities, and others including the Personal Care Assistant program.
- Through the Money Follows the Person waiver program, and Comprehensive Screening Service Model, the ASAPs assist nursing facility residents to return to the community; this includes Individuals with ABI, I/DD, SMI and physical disabilities. Many require significant multidimensional supports to transition successfully including housing, behavioral, recovery, and other LTSS needs often with increased acuity due to the absence of family and friends.
- BCIL, BSHC, MVES and SCES coordinate care for over 1,000 people with disabilities under the age of 65 who are enrolled in One Care.
- Bay Cove and Vinfen coordinate care for approximately 3,500 people with SMI and or SUD through CBFS programs.

7.3 B Experience in and approach to coordination among physical health, behavioral health, and LTSS providers

1. Working with medical, LTSS, behavioral health and social services providers

All BLTSSCP Members have considerable experience with care coordination across different types of providers - medical, LTSS, behavioral health (BH) and social service - with the consistent focus on the development and implementation of person-centered care plans while assisting Individuals to achieve their health care and personal goals. A care coordination relationship begins with an assessment process in which a care coordinator gains the Individual's consent, gathers information from the Individual, the Individual's family and the Individual's providers of care including medical, BH, and LTSS. The assessment process is the first step in building a relationship both with the Individual and with the Individual's providers of care.

Following the assessment process, the Care Coordinator and the Individual develop a care plan that allows the Individuals to make meaningful decisions about the services and supports they receive including how these services meet their life-goals, where they live, with whom they live, who supports them, what training is critical for a caregiver, who is on the care team and what LTSS services and providers are available. As part of the care plan development process, all of the providers and organizations involved in the Individual's care are identified, including contact information. With the Individual's consent, the care coordinator contacts each as appropriate to provide information regarding services and the role of the Care Coordinator. The Coordinator also assists Individuals in resolving issues with other providers and organizations.

Implementing the care plan is an ongoing process and often requires the Care Coordinator to research and arrange for services for the Individual. Coordination among providers is key to implementing the care plan and can be done telephonically and as needed. care team meetings and/or consultations are arranged to ensure coordination across all silos and settings. Members identify and establish ongoing, positive relationships with local systems and individual providers of physical health, BH, LTSS and social services who have relevant experience and a reputation for success in serving people with LTSS needs. Members work with a wide range of providers too numerous to name and falling in the following categories: hospitals, specialty medical, community health centers, primary care; rehabilitation centers, inpatient psychiatric hospitals, chronic disease hospitals, outpatient MH, SUD providers, visiting nurse associations, home care agencies, housing and homelessness organizations, and linguistically and cultural diverse resources.

2. Providing LTSS subject matter expertise to providers

All Members of BLTSSCP interact with, educate and respond to health care, behavioral health and social service providers through their coordinators, administrators and clinicians. Each Member has nursing staff and several have other types of clinicians trained in integrated health who are experienced in LTSS services and care coordination among caregivers and providers. Education and expertise is provided regularly in the course of care planning for individual cases, and also provided in more formal methods such as Bay Cove's Speakers' Bureau that is made available to various audiences including health care providers in order to share information on LTSS.

BSHC, MVES and SCES are frequently called upon to educate hospital systems and other service providers about LTSS, including the scope and limitations of service types, the LTSS needs of Individuals, environmental barriers to care, and service availability. Bay Cove, JRI and Vinfen provide LTSS subject matter expertise to health care, behavioral health, and social

services providers, educating representatives of local systems of care and individual community health and behavioral health providers. The organizations have expertise in the health and behavioral conditions of people with LTSS needs and provide education to medical and BH providers on how general health and behavioral care issues manifest differently in people with LTSS needs, such as the cluster of psoriasis, respiratory, cardiac, and early-onset dementia related to Down's Syndrome. The organizations are subject matter experts on best practices for health and behavioral health care providers treating people with LTSS needs, such as sensory appropriate care for children and adults with Autism.

3. Promoting Integration of Care across physical, behavioral health, LTSS, social services

BLTSSCP defines "Integration of Care" as system re-designs that bring together services that are typically separate and often provided by separate organizations. Sometimes, Integration means co-locating services; in other situations, Integration involves workflows or protocols that require different service providers to work together in service to the Enrollee. In contrast, Care Coordination, is the act of managing or organizing care across existing systems and providers with no changes to the systems themselves. BLTSSCP Members have extensive experience coordinating care as discussed in Sections 7.3 A 1, 7.3 A 3 and 7.3 B 1.

In contrast to the evidence based SAMHSA model for integrating BH and medical care where BH providers are co-located at primary care practices, a literature review turns up few evidence-based programs for the integration of LTSS with medical and BH services. There are health plans that integrate the payment for medical, BH and LTSS and there are pilot programs that integrate BH and LTSS or LTSS and medical care. This is an area ripe for testing and innovation. The Enhanced LTSS CP program will provide further opportunities to test and implement new programs to integrate care across the silos of BH, physical health, LTSS and social services in partnership with ACOs. Meanwhile, four of the seven Members have tested approaches to Integration:

- MVES and SCES partner with Cambridge Health Alliance and Hallmark Health on a care transitions program. In order to reduce hospital readmissions, ASAP Care Coordinators serve as "transition facilitators" and collaborate with hospital clinicians, pharmacists, social workers and primary care providers to ensure a comprehensive transition plan is developed and implemented for each hospitalized patients. Care Coordinators are physically located on the hospital floor, use the same IT systems as hospital employees, participate in hospital discharge planning meetings, but are employed by, supported by and can rely on the resources of the ASAP to meet the vast array of LTSS and social service needs of the patients. Over four years the program has reduced 30 day hospital re-admissions.
- Bay Cove and Vinfen, using a reverse integration approach, have embedded primary care Nurse Practitioners into community-based psychiatric rehabilitation teams that serve people with SMI, 60% of whom are high LTSS users as well. Funded through a three-year Innovation grant from CMS, the program integrated physical, BH and LTSS services at the Bay Cove and Vinfen team level and resulted in reduced Emergency Department use.

BLSTSSCP Members "promote" the Integration of care across service types in a number of ways currently. Clinical and outreach staff at Bay Cove, BCIL, JRI and Vinfen promote the integration of care through ISP and Day Habilitation Plan meetings, accompanying Individuals to medical and other appointments, maintaining communication with other members of the Team, and internal referrals to Clinical Rounds and Risk Committees. All Members ensure that routine,

specialty and preventive care is provided and consistent with current best practice protocols such as the DDS Preventive Health Screening recommendations which include timelines for routine evaluations. All needs, preferences and recommendations are documented for the Individual's Team to ensure that care is integrated and coordinated. All Members maintain and nurture relationships with a wide variety of hospitals, community health centers and physician practices, rehabilitation facilities and providers of behavioral health services. The coordination of care across physical, behavioral health, LTSS and social services contributes to the best outcomes for Individuals and maximizes their ability to achieve their personal goals.

7.3 C MassHealth Managed Care Programs

BLTSSCP Members have extensive experience working with MassHealth managed care programs. The experience includes contracts for care management, LTSS coordination, PCA services, outpatient mental health, day habilitation, CSA/CBHI, and Adult Day Health. The following are examples of those experiences:

- One Care plans: Six Members have worked closely with Commonwealth Care Alliance (CCA) in several roles since the start of the program in 2013. BCIL, SCES, MVES and BSHC all provide Long Term Services and Supports Coordination (LTSC) to One Care Enrollees that includes LTSS coordination and development of an LTSS care plan. Together they provide LTSC services to over 1,000 Enrollees. Bay Cove and Vinfen each contract with CCA to operate a One Care Health Home where they manage the medical, Behavioral Health and LTSS for a combined total of over 400 Enrollees with disabilities. SCES, MVES and BSHC also provide LTSC services to Tufts One Care Enrollees.
- Senior Care Options (SCO): MVES, BSHC and SCES have provided Geriatric Support Services Coordination (GSSC) for Senior Care Options (SCO) Enrollees since 2004 including contracts with Commonwealth Care Alliance, United, Senior WholeHealth and Tufts. GSSCs conduct LTSS assessments, recommend LTSS care plans, authorize and implement LTSS care plans, and monitor the provision and outcomes of services. GSSCs educate the team regarding LTSS and other community resources. The GSSC advocates for community care on behalf of SCO members when institutional placements are contemplated. ASAPs also procure and manage the LTSS provider network on behalf of four of the six SCOs.
- MassHealth MCOs: Bay Cove, JRI and Vinfen hold contracts with MassHealth MCOs to provide outpatient MH services, day habilitation services and PACT services to Enrollees. JRI also provides CBHI/CSA services. JRI estimates that its MassHealth managed care revenue in 2016 was $14 million and will grow to $20 million in 2017.

All Members have experience conducting the MDS-HC assessment for LTSS through contracts with EOEA, MassHealth, One Care plans and SCO plans. BCIL also provides PCA services to One Care Enrollees and other MassHealth managed care Enrollees.

7.3 D Collaboration with other State Agencies, Organizations, and Providers

All BLTSSCP Members are experienced in collaborating with state agencies, providers, social services organizations in order to provide better services to the Individual. Members understand that fostering and nurturing relationships with provider organizations and local resources are essential for effective service planning and implementation. In working with multiple state

agencies, organizations and providers, all Members have had the opportunity to participate in many new initiatives. One example of this is DDS's grant award to Vinfen for a project to promote social inclusion. Vinfen was asked to participate in a project on the same topic sponsored by Arc of MA that includes collaboration with 15 other providers to share ideas, best practices and successes. Also, Vinfen has partnered with UMass Medical Center (UMMC) to submit a federal grant on this topic and participated in the development of the proposal with UMMC staff.

All Members are experienced working with multi-agency teams on behalf of all populations targeted in the LTSSCP program. Through the teams of the DDS Individual Service Plans, the Individual Education Plans for children, the Day Habilitation Plans, and others, the Members work together with staff of the respective state and/or local entities and other providers of service and organizations, on planning and implementing visions, goals and support strategies. Additional or different issues or challenges at times emerge outside the established process. One example of this is the Risk Reviews that occur on behalf of the individuals served by DDS when medical, behavioral, forensic, or care transition challenges present as critical. All team members from any involved state, provider agencies, or organizations as well as other involved parties such as clinicians come together to develop a plan that may indicate referrals to other services or supports.

Members adopt best practices from the literature, and embrace key principles of care coordination, including Self Determination at the core of services provided. Maintaining the Individual's needs and preferences at the center of planning and implementation addresses the resolution of many possible conflicts. Use of the multi-disciplinary team approach with all parties contributing to produce negotiated plans and positive outcomes; as well as fostering relationships with and respect among all team members facilitates conflict resolution.

7. 3 E Experience with Alternate Payment Methodologies

1. Bay Cove and Vinfen have had contracts with Commonwealth Care Alliance (CCA) for One Care Health Home services since March 2014 and are paid as follows: a PMPM for care management based on the Enrollee's MassHealth One Care rating category; an additional fee for the annual in-person comprehensive assessment (MDS-HC) and care plan developed by an RN; and bonus payments of up to 25% of the care management PMPM. For the first three years of the program, Bay Cove and Vinfen were evaluated through the following quality measures: comprehensive in-person assessment/re-assessment and care plan timely completion and post-acute care home visit within 48 hours by an RN. Both Members have been successful in earning bonus payments for those measures. In 2017, the quality measures were revised and are as follows: initial assessment and care plan development timeliness; post-acute care visit to Enrollees within 48 hours; and reduction of hospital admissions (per 1,000, per year). Results from the new quality measures are expected in 2018. There is no downside risk or shared losses in the contract.

2. BLTSSCP understands that an increasing portion of the PMPM payment from MassHealth will be subject to a quality withhold over the length of the LTSS CP Contract period. We will draw upon its experience managing its performance and value based contracts with CCA for its

approach to measuring its financial performance in the LTSS CP program. In arrangements with CCA, Bay Cove and Vinfen receive quarterly claims data sets that they use to understand their Enrollee's total medical expenses (TME) and key drivers of TME such as spending on inpatient, LTSS, pharmacy and Emergency Department. In addition, they receive quarterly reports on its performance compared to other similar entities with CCA contracts. For the LTSS CP program, we will take the following approach:

- Track and document quality measures at the Enrollee level to ensure that LTSS Care Coordinators are meeting the measures. The BLTSSCP Care Coordination IT platform will capture the data elements required to track quality measures.
- Request quarterly claims data from the ACO/MCOs as well as from MassHealth for the Primary Care ACOs. Using quarterly claims data, BLTSSCP will track its performance longitudinally for key quality and utilization measures as well as for total cost of care. Request performance data from ACO/MCOs comparing BLTSSCP to other LTSSCPs to understand how its performance compares to peer organizations.
- Although withholds will not initially depend on achieving cost savings, BLTSSCP will begin to develop initiatives to address these objectives as soon as claims data becomes available.

Based on the monthly analysis and quarterly Quality Management Committee (QM Committee) reviews, BLTSSCP will implement quality improvement programs to address any challenges. In its contracts with CCA, Bay Cove and Vinfen have conducted several quality improvement initiatives over the past three years. One example is an initiative to review skilled nursing visits to Enrollees for medication management in their home to assess whether there are less costly, yet, as effective LTSS alternatives to be implemented. Vinfen successfully reduced unnecessary utilization in this area while maintaining quality of service. Another example is an initiative that targeted Enrollees who did not refill their prescriptions for Diabetes treatment in order to identify barriers and address those through education and support with accessing medication.

7.3 F Quality and Performance Measurement

1. Experience working with quality measures and performance based outcomes

Each Member of BLTSSCP is committed to continuously improving the quality of life for individuals receiving supports, and each is experienced in working with quality improvement assessments, analysis, outcomes and resultant plans as tools in achieving improved quality.

- Vinfen uses a Balanced Scorecard system which develops annual objectives from multiple data sources and external scans, collects data on a wide range of clinical, utilization, satisfaction and engagement measures and processes data to shape implementation modification of annual and multi-year initiatives to improve performance. Vinfen engages multiple stakeholders in assessing quality, through surveys and advisory councils of consumers and families.
- JRI's Performance Improvement Plan ensures that available resources are utilized in an effective manner to provide high quality and clinically appropriate services. The quality of processes, interventions, services, education and treatment is measured and monitored through the use of risk management and outcome data which are collected and recorded in a client assessment system. Critical aspects of care are identified by JRI leadership and prioritized for review/assessment based on those that are high risk, high volume, high cost or problem-prone.

- Bay Cove utilizes a Quality Management system that incorporates performance based outcomes, consumer satisfaction, utilization tracking and analysis and other quality management practices including: Annual Satisfaction and Quality of Service Surveys with all Stakeholders, DDS Performance Based Contracting outcomes reporting, Risk Assessment and Management, Stakeholder Annual Satisfaction Surveys, and Participant interviews.
- BCIL utilizes the varying requirements of their ten contracts to track activities, record service provision, and detail expenditures. Client satisfaction is measured through an annual survey.
- BSHC, MVES and SCES maintain a comprehensive quality assurance program that addresses all aspects of LTSS management and delivery including timeliness and quality of care management, service provision and quality and consumer satisfaction. Data is collected through a variety of means including claims, surveys, interviews, evaluations, care plans and record reviews. Measures are tracked and reported monthly, quarterly and annually and feedback is regularly communicated to responsible managers.

2. Bidder's experience with a specific quality improvement initiative that resulted in improved member outcomes and improved quality of care.

BLTSSCP Members all have significant experience in developing and managing initiatives to improve outcomes and quality. Following are some examples:

- Bay Cove expanded health care monitoring systems in DD Services by increasing the number of nurses on staff to facilitate regular assessment of health care needs, monitor medication administration, and direct communication with health care providers. There has since been a significant increase in Bay Cove's ability to identify and address health issues earlier, decrease hospitalizations, increase quality of life, and provide in-home End of Life Care.
- JRI implemented 'Impact Ability,' a comprehensive abuse prevention project including a comprehensive revision of operational policies, procedures and training curricula which resulted in improved individuals' engagement in and awareness of abuse reporting, prevention and response activities as well as the formation of four self advocacy groups.
- Vinfen implemented a Quality initiative called 'Sustainability' to review and revise systems and practices to ensure long-term sustainability, retention of institutional learning and the consistent use of proven practices. One outcome, the collection and review of data regarding routine medical appointments, has resulted in improved consistency of medical care for individuals.
- BSHC, MVES and SCES have engaged in a multi -year project to improve the quality of care to individuals with Alzheimer's disease. Elements of the plan include the implementation of new assessment procedures, appropriate referrals to medical and community organizations, and the development of a certification in care with the Alzheimer's Association. This project has resulted in improved outcomes and quality of life for individuals and their caregivers.

7.3 G Alignment and Experience with System Reform Initiatives

The Community First vision is exemplified in the supports offered by BLTSSCP Members. The roadmap and action plan developed through the Community First Olmstead Plan is consistent with the missions of each Member. Bay Cove 'partners with people to overcome challenges and realize personal potential,' BCIL 'promotes greater independence for people with disabilities,' JRI 'advances social justice by opening doors of opportunity for those who are otherwise barred

from them,' and Vinfen 'transforms lives by building the capacity of individuals, families, organizations and communities to learn, thrive, and achieve their goals.' All Members have embraced the goals of self advocacy promotion, community/social inclusion, and control over one's own services has shaped the growth of and drives the need for long term services, and several, including Vinfen and Bay Cove, have launched special self-advocacy training for individuals with disabilities.

The Members have extensive histories of developing innovative community-based services for all populations targeted in the LTSS CP program that allow Individuals to remain in the community. Examples include the expansion of accessible and affordable housing options and new programs such as intensive residences for individuals with I/DD or ABI and intense medical needs, Adult Foster Care, Shared Living and Personal Care Attendant programs.

7.4 Information Systems and Reporting Capacity

A. Describe its information system and architecture, including the name of the systems and vendors the Bidder uses for electronic health record (EHR), hardware, billing, customer service, care coordination, care planning, provider rosters, financial, etc.:

Based on recent experience, guidance from nationally recognized IT consulting firm, Gartner, and information gathered from planning sessions with ACO/MCOs, BLTSSCP leadership has decided to contract with a Care Coordination Information Technology (CCIT) vendor rather than build out existing EHR systems. The new CCIT system will be designed to meet the care coordination, data warehouse, and data exchange requirements of the LTSS CP program.

BLTSSCP's Member senior leadership, including senior IT, Quality and Care Coordination staff, have reviewed in detail a number CCIT vendors that provide care coordination platforms with data analytics and data exchanges, including Arcadia, LoopBack, LightBeam, Care Navigator, Evolent Health, and CORE Solutions. In conducting these reviews, BLTSSCP was guided by Gartner, contracted with Vinfen, to provide advice on issues of functionality and pricing of these systems and the companies which develop and manage them. As soon as feasible after the CP awards have been announced, BLTSSCP will select and contract with the most appropriate vendor, and then configure and implement a CCIT system designed to meet the requirements and timeline of the LTSS CP program. BLTSSCP's vendor choice will have a significant track record of working with health systems across the country and in Massachusetts, with features and functionality designed to meet the requirements of the new ACO system.

The new CCIT system will have the following features: secure internet access to the system for entering (in forms templates), storing, managing, reviewing and reporting on individual and aggregate client data; a data warehouse; extraction and transmission (Health Information Exchange, or HIE) functions to connect and manage information exchanges with ACO/MCO and community partner systems; data analytic capacities; easy access reporting and dashboard functions; and the capacity to use the Massachusetts HIE as it develops. EMCP has conducted detailed discussions with candidate vendors sufficient to forecast costs for contracting, configuring, implementing, and maintaining a CCIT system. Estimated costs for the CCIT are documented in **7.5.G. Budget Report and Budget Narrative**.

The seven Members of BLTSSCP, Vinfen, Bay Cove, Boston Senior Home Care (BSHC), Boston Center for Independent Living (BCIL), Justice Resource Institute (JRI), Mystic Valley Elder Services (MVES), and Somerville Cambridge Elder Services (SCES) have proven track records developing and managing IT systems for large numbers of staff, large populations of clients, and multiple referral and funder sources which meet requirements of MassHealth and EOHHS agencies for data collection, management, and reporting in domains including service planning and utilization, billing and finances, quality and outcomes. Some of the Members use commercially available EHRs (Bay Cove uses eHana and a company-developed Electronic Health Record (EHR) IT system; Vinfen now uses Icentrix, and has contracted with Core Solutions to implement a new EHR system with even more robust functionality. JRI uses eHana for its children's services and Icentrix for its adult services. Boston Senior Home Care, Mystic Valley Elder Services, and Somerville Cambridge Elder Services use the Massachusetts EOEA

system called Social Assistance Management System SAMS to document their LTSS care coordination work through the following programs: Home Care, intake and referral, Meals on Wheels, Clinical Assessment and Eligibility. In addition, BSHC, MVES and SCES document their LTSS care coordination work in the electronic health records systems for each Senior Care Options (SCO) contract and One Care contract that they hold with MassHealth managed care organizations.

BLTSSCP members each employ an intranet-based IT system throughout their respective organizations with a combined total of over 9,000 end-user devices of varying types, including PC's and mobile devices, supported by stable and effective data centers and IT staff.

In order to leverage existing resources and reduce the added costs needed to manage a new CCIT system, the Members have decided to delegate the CCIT management to Vinfen. Vinfen's IT team, working with the seven Members as needed, will have primary responsibility in the configuration, testing, implementation, and management of the new CCIT system. Vinfen currently manages a comprehensive IT platform which functions in all relevant domains, including both cloud (SaaS, public and private cloud architecture) and internally hosted systems at Vinfen's data center, which has been designed and maintained in order to meet current standards for technical performance (uptime and connectivity) and compliance requirements. Vinfen's data center currently hosts more than 100 server environments, and 160 terabytes of data.

Vinfen's system security currently includes encrypted email, HIPAA compliant file security, individual level privileging which allows employees access to information and data required for their specific job roles and programs, and anti-virus, anti-spam and anti-malware protections. Vinfen's system is periodically assessed for performance in security and compliance by external parties to ensure that the company has the technical and management systems in place to identify and respond to any weaknesses or threats.

B. Describe how it will receive, create, access, store and transmit health information with EOHHS, ACOs, MCOs, and other providers within HIPAA standards. Such description shall include:

Current and proposed uses of Electronic Health Records (EHRs) in care delivery:
Service staff of all types and roles (physicians, nursing, clinical, outreach, and residential direct care) across all Members use IT systems to enter information and data on services, including demographics, diagnoses, symptoms and functioning, medications and prescribed devices and services, care plans with assessments, goals, objectives, interventions, progress notes, claims, standardized functional rating tools, real-world outcomes, and medical data. All Members also manage IT systems which collect, store and exchange a complex array of financial data, including service events, billing, collection, reconciliation, service utilization, financial statements of performance and position, and report on these data and actions in a variety of formats which allow for timely monitoring and interventions by management, and timely reporting to external funding sources. Finally, the Members also manage quality and outcome data systems which collect and manage data on a range of domains, including customer

satisfaction and engagement, progress and outcomes in symptoms, and standardized assessment tools.

Current and proposed methods for information sharing with ACOs, MCOs, EOHHS, and other providers:
In planning discussions with 12 MassHealth ACO Bidders, BLTSSCP has learned that they are at very different stages of developing IT systems for exchanging and managing data with LTSS CPs. As noted above, BLTSSCP plans to contract with a vendor to acquire, configure, implement and manage a CCIT system inclusive of technology to ensure secure, compliant transfer of information between CPs and ACO/MCOs as required.

Although BLTSSCP has experience and will, if necessary, enter data into ACO/MCO systems, BLTSSCP is committed to acquiring and managing a CCIT system as the primary resource for managing data and information. BLTSSCP Care Coordination staff will enter data into the CCIT system directly rather than into Electronic Health Records (EHRs) of the CE's or any potential partners. It has become clear that for financial and logistical reasons, it is not feasible to consider alternative plans which would require CEs and potential partners to develop CCIT systems within their own EHRs. Therefore, the BLTSSCP CCIT system will be the primary source of data and information, and will have data warehouse capacities for analytics, reporting, and secure exchanges with ACOs/MCOs and any affiliated community partners.

In the event that there are delays in establishing exchanges with ACOs/MCOs, Members do have experience entering data into and receiving reports from other systems used by multiple health care provider organizations. For example, Bay Cove has developed and works with the Boston Emergency Services Team system. Vinfen, Bay Cove, SCES, MVES and BCIL care coordination staff document in Commonwealth Care Alliance's EHR system for their One Care Health Home and Long Term Services and Support Coordinator services. SCES and MVES document in the ACO Bidder, Cambridge Health Alliance's EHR system.

Current and proposed uses of the Mass HIway and other secure information exchange methods:
The Vice Presidents of IT at Vinfen and Bay Cove participate in a special EOHHS committee planning for interoperability in the community health and human services system and have participated in forums on the current and forecasted status of the Massachusetts HIway. Based on information to date, as noted above, BLTSSCP will engage a vendor to develop and manage a CCIT system to collect, store, facilitate analyses and reporting, and exchange data across a large number of ACO/MCO entities, (now estimated at 12), and any potentially affiliated community partners. As the Mass HIway becomes more fully developed, BLTSSCP will continue to develop the CCIT platform to take full advantage of the data transmission opportunities that it offers.

Capabilities to successfully send and receive eligibility files in an electronic format from EOHHS:
The CCIT systems which BLTSSCP has reviewed have the capacity to send and receive a variety of eligibility files. Once eligibility file specifications are released by MassHealth, BLTSSCP will ensure that the system it selects can meet those requirements. Members are familiar with the operations required to check MassHealth eligibility, and are also familiar with the challenges that MassHealth Members face in maintaining eligibility as their illnesses and

their social and economic situations change. Members currently check MassHealth eligibility frequently through eligibility verification systems, and will ensure such a system is in place for the LTSS CP program.

System security and access controls:
As noted above, Members currently manage and continuously upgrade IT systems and policies and practices to meet the technical specifications for security and to comply with HIPAA and related requirements. All Members have security technology and practices built into their systems, including encrypted emails with transport-layer security, and robust anti-virus and malware protections.

BLTSSCP recognizes that all Members will be required to demonstrate technical security, such as protections against viruses and malware and individual level credentialing to protect against unauthorized access to protected health information, within their organizations and in data exchanges, and plans to develop processes for compliance testing and reporting to ensure protections are in place.

Current uses of care management tools and software:
Members currently use a wide array of care management tools and software systems across different programs and state agencies. Examples include: 1) Bay Cove and Vinfen use the Massachusetts Standardized Data Program (MSDP) form sets which have been approved for use by DMH, DPH, MassHealth and the Behavioral Health managed care entities in Massachusetts; both organizations have incorporated the form sets in their internal systems; 2) Bay Cove, Vinfen, MVES, SCES and BSHC use the MDS HC form in their assessment and care coordination with One Care and the Senior Care Options (SCO) program; 3) Bay Cove, Vinfen, SCES, MVES and BCIL input information into Commonwealth Care Alliance's EHR for the One Care programs; 4) Bay Cove utilizes the form sets and data exchange through its contract with the Boston Emergency Services Team; 5) Bay Cove, JRI and Vinfen use the Department of Developmental Services Individual Service Plans forms and data through the DDS intranet-base Home and Community Services Information System; 6) MVES, SCES and BSHC use the EOEA SAMS system for documenting LTSS coordination work for several EOEA programs; and 7) MVES, SCES and BSHC contract with several Senior Care Options (SCO) programs and document directly into the Centralized Enrollee Record of those programs.

The Members' current systems also capture information and data on medications, medical devices, selected health conditions and interventions by medical specialties within existing electronic records. And both systems capture the increasingly recognized as important data on key social determinants of health including housing, employment and economic status.

The BLTSSCP will develop a LTSS CP template designed to capture the required elements for the LTSS CP program and will be incorporated in BLTSSCP's CCIT system (See **7.3.C.**).

A. Executive Summary

Boston LTSS Community Partners (BLTSSCP) is a newly formed organization that brings together seven Community-Based Organizations to provide LTSS CP services to people with complex LTSS needs. Each Member organization is a leader both in its local communities and in its field of service. Bay Cove and Vinfen are known for their expertise in providing a wide range of community based services to people with Intellectual and Developmental Disabilities and Autism Spectrum Disorders many of whom also have co-occurring medical and behavioral health challenges. The three Aging Service Access Point (ASAP) organizations – Boston Senior Home Care, Mystic Valley Elder Services and Somerville Cambridge Elder Services - have broad and detailed knowledge of the long term care system, including LTSS management, and they provide unbiased information to individual about their LTSS options through information and referral programs. Boston Center for Independent Living, founded in 1974, by and for people with disabilities, was the first Personal Care Management agency in Massachusetts, and provides options counseling and LTSS coordination for a range of people with disabilities. Justice Resource Institute, one of the largest human services providers in New England, operates over 100 programs serving diverse populations including a range of community based services to children and youth with behavioral challenges and disabilities.

BLTSSCP Members are committed to the goals of the LTSS CP program: to support Enrollees with complex LTSS needs to live healthfully and independently in the community by strengthening linkages between health care providers and Community-based Organizations, by providing Individual-centered care coordination and choice counseling. Evidence of this commitment is found in the history of programming at each Member organization that coordinates care for a range of populations across systems. MassHealth reforms will create the necessary structure for the LTSS CP program to be successful by holding providers accountable for total cost of care. This shift will encourage ACOs to expand their programs for people with complex LTSS needs that have only previously occurred on a much smaller scale.

The LTSS system is fragmented and can be difficult to navigate for Individuals and families. Each LTSS service has different eligibility criteria and assessment process. Service specialization in LTSS is critical to meeting the needs of specific populations. At the same time, not all LTSS providers are aware of the range of services and the eligibility criteria and determination process for each. As a result, Individuals may be referred to a particular service and provider but may not be aware of the breadth of their options and may be receiving care that is not fully aligned with their needs. For most Individuals, the LTSS system remains disconnected from the systems of medical and behavioral health care. Individuals with LTSS needs may have multiple providers of service but no single person that is coordinating care across systems and settings. Moreover, people with LTSS needs are among the most medically and behaviorally complex and costly patients in the medical care system. The result of the disconnection between systems is missed opportunities to use LTSS to reduce use of more costly services such as inpatient, Emergency Department and to prevent institutional placement.

The LTSS CP program that BLTSSCP proposes will address many of the challenges outlined above. The structure of BLTSSCP that brings together seven organizations with both specialized service offerings and a broader overview of the range of LTSS service options and experience in Options Counseling will be the first step in addressing fragmentation within the LTSS system.

BLTSSCP will leverage the experiences of Members to convene Learning Collaboratives, and develop training curriculum and service resource directories.

BLTSSCP recognizes that to best serve Enrollees, LTSS CP services must be provided in close partnerships with ACO/MCOs, the entities at risk for Total Cost of Care in the new delivery system. As a result, BLTSSCP will build on its existing relationships and methods for collaboration with ACO/MCOs and invest additional staff resources to develop collaborations to coordinate care, reduce duplication of services, and target limited resources to the right Enrollees at the right time. All BLTSSCP Members have experience participating on interdisciplinary care teams and coordinating with a range of providers in their roles as Long Term Service and Support service coordinators for One Care, as Home Care coordinators, as residential- and Day Habilitation- based coordinators, CBFS providers, and CSAs. In addition, the Members of BLTSSCP are prepared to share both their specialized LTSS service knowledge and options counseling expertise with medical providers and care managers within ACO/MCOs.

BLTSSCP welcomes the opportunity to expand services to ACO/MCO Enrollees with LTSS needs who may not currently have access to LTSS coordination services and choice counseling. BLTSSCP's designed Capacity will support 1,400 Enrollees, after a 12-month ramp-up period. BLTSSCP's enrollment projections take into account estimated numbers of ACO/MCO referrals and existing clients in specific Service Areas as well as estimated participation rates. BLTSSCP will serve all of the Greater Boston Region, the Service Areas of Brockton and Malden.

BLTSSCP will employ a management team that is responsible for overall performance and contract management with EOHHS, ACO/MCOs and Members. This team will be responsible for developing operational and programmatic elements of the LTSS CP program including training curriculum for Care teams, the Learning Collaborative, an intake process for accepting ACO/MCO referrals and assigning them to care teams, and the Consumer Advisory Board. Each Member will operate locally based care teams that utilize each organization's community-based relationships and expertise in working with particular populations to provide the core LTSS CP services. Other administrative functions will be delegated to Members: Vinfen will provide IT, marketing and quality management; Bay Cove will provide financial management and HR services. Below are key milestones with timeframes for operationalizing the LTSS CP program:

- ACO relationship development – Members began planning sessions with several ACOs/MCOs nine months ago; these will continue until contracts are final in 2018;
- Intake/referral system – BLTSSCP will develop a system for accepting Enrollees from ACO/MCOs and assigning them to local care teams for engagement;
- Central Management team–key leadership positions including the Executive Director will begin November 2017 to January 2018;
- Information Technology systems – BLTSSCP will select a CCIT in September and configure the system for the following 6 to 9 months;
- Care team start up – 7 LTSS Care Coordinators will begin in March; additional staff will be hired based on Enrollment volume.

In implementing the LTSS CP program, BLTSSCP will develop infrastructures and capacities that will sustain the program over the Contract term and beyond. These structures include Information Technology systems, a Quality Management program, a workforce trained in LTSS coordination, an organizational governance structure that facilitates the collaboration of seven separate organizations, and strengthened relationships with ACO and MCOs.

7.5 B Supporting Populations and Community Engagement

1) BLTSSCP recognizes the importance of developing positive relationships with a variety of community organizations in order to enrich the lives of and services for people we support as well as building relationships with organizations that can assist with meeting the needs related to the social determinants of health. Each Member is deeply rooted in their communities and has a wealth of experience in networking with community resources for services and supports as well as encouraging and facilitating community inclusion. This combined expertise stretches across the focus populations and across the service areas included in this proposal. These combined resources position BLTSSSCP to provide information and referral services to Enrollees and their families and provide linkages to a wide variety of resources. Each Member encourages and supports people to become active members of their communities. Individualized person-centered profiles and preferences are used to develop community connections that address religious affiliations, educational services, recreational interests, and employment opportunities. Our relationships extend to Neighborhood Health Centers and other community health networks in the Boston, Revere, Quincy, Somerville and Brockton Service Areas as well as hospitals in all Service Areas.

Region/SA	Social Service/Municipal/Community Organizations	LTSS Providers/Advocacy Groups	Housing and Homeless Shelters
Northern: Malden	Everett, Malden, Medford, Melrose and Wakefield Councils on Aging, MSG Staffing (health care staff), Seasons Hospice and Palliative Care	Eliot Community Human Services and Riverside Community Care (emergency psychiatric and behavioral screening and services)	AIDS Action Committee, MBHP, ABCD and Community Action Programs Intercity, Inc.
Greater Boston: Boston	Community Servings, Dorchester Boys and Girls Club, Urban Pride, Special Townies, Greater Boston Food Bank, Elder Care Alliance, Suffolk County Aging Disability Consortium, Age Friendly Boston, Boston Memory Cafes, COMPASS, Boston Partners in Mentoring and Alliance for Inclusion and Prevention	Multicultural AIDS Coalition, Boston Area Gay and Lesbian Youth, AIDS Action Committee, St. Mary's Center, Casa Myrna Vasquez, Horizons for Homeless Children, SPARK@ Boston Medical Center, Massachusetts Association for the Blind, Hearth, City Psych, Gandara and South Bay Mental Health	ABCD, Living and Recovery Center, Boston Housing Authority, Pine Street Inn, Rosie's Place, Health Care for the Homeless, Rebuilding Boston Together, Homestart, Tenancy Preservation Project, Boston and Brookline Housing Authorities, MBHP and Jewish Community Housing for the Elderly
Greater Boston: Revere	Chelsea Council on Elder Affairs, Revere, Winthrop Councils on Aging and Community Action Providers Inter-City, Inc.	Chelsea HUB and Nizhoni Health Services	Community Action Programs Intercity, Inc.
Greater Boston: Somerville	Cambridge and Somerville Councils on Aging, Paine Senior Services, Cambridge Economic Opportunity Committee and SCM Community Transportation	Multiservice Center of Cambridge, Cambridge Health Alliance, Cambridge and Somerville Mental Health and Aging Coalition and CASCAP	Cambridge and Somerville Housing Authorities, Homeowners Rehabilitation and Somerville Homeless Coalition
Greater	Interfaith Social Services, Quincy	Choice Community Supports	Father Bill's Place,

Boston: Quincy	Community Action Program Bay State Community Services, DOVE and New Life Counseling and Wellness	and South Shore Mental Health Center	Neighborhood Housing Service and NeighborWorks
Southern: Brockton	East Bridgewater YMCA, Catholic Charities, Cape Verdean Association, BAMSI and Brockton Family and Community Resources	Brockton Area ARC, Brockton Area Multi-Services, Inc., Horace Mann Educational Associates and Enable/First Steps	Mainspring House
Across Service Areas	Outdoor Explorations, Local Health Centers, Deaf Inc, Easter Seals, Greater Boston Legal Services, MA Alliance of Portuguese Speakers, SHINE, REquipment, Get Palliative Care Resource, Jonah & the Whale Foundation, Catholic Charities	Aging and Disability Resource Consortium, Massachusetts Advocates Standing Strong, ARC Massachusetts, Institute for Community Inclusion and MA Advocates for Children	Department of Housing and Community Development, Citizen's Housing and Planning Association and Preservation of Affordable Housing

2) Through its Members, BLTSSCP has a presence, provides services and supports and community connections in the Brockton, Quincy, Malden, Revere, Somerville and Boston Service Areas. BLTSSCP will immediately implement a robust outreach plan that builds on its existing connections and partnerships with the local community. These existing connections will be used to enhance and explore resources, network with other community resources and forge new partnerships based on current and anticipated needs of Enrollees. Trade organizations such as the Association of Developmental Disability Providers (ADDP) provide opportunities for sharing resources and information.

BLTSSCP will expand the scope of the Community Mapping that has been actively used and productive in Vinfen's service system. The catalyst for the use of this system, for which Vinfen has recently been awarded two grants, has been the focus on Social Inclusion in the community for individuals with disabilities. Community Mapping is a tool for staff to research and document community resources local to an individual's residential setting. This resource research and development tool will support Care Coordinators efforts to grow community connections on behalf of Enrollees.

3) The over 40 years of experience of Bay Cove, BCIL, BSHC, JRI , MVES, SCES and Vinfen has resulted in an extensive array of resources to be shared among the Members. A Learning Collaborative will be developed to facilitate the sharing of existing resources among Care Coordinators. Agenda items will include discussing strategies for the development of new resources including Community Mapping and sharing of identified resources. In person meetings and electronic exchange of information and questions will enhance the identification of resources to present to Enrollees. Specific contact and referral information will be gathered, recorded and maintained. Care Coordinators will have up to date access to this information through an electronic BLTSS Resource Directory of available community health and social service resources that will be developed across all Service Areas.

7.5 C Community Partners Supports and Activities

Describe plan to provide LTSS CP Supports

The foundation of BLTSSCP's work will be established on effective practices in seven domains: 1) Outreach and active engagement, 2) LTSS Care Planning, 3) Care Team participation, 4) LTSS Care Coordination, 5) Support for Care Transitions, 6) Health and Wellness Coaching and 7) Connections to Social and Community Services. BLTSSCP Members are well established community based organizations well positioned to bring extensive and demonstrated expertise in all required areas of LTSS CP functions and activities.

1. Outreach

In order to ensure the continuity of all elements of outreach activities, a checklist will be developed by BLTSSCP for the use of LTSS Care Coordinators both as a guide for discussion and as a documentation tool during Outreach and Planning. This checklist will be placed in the Enrollee's file, entered into Care Coordination Information Technology (CCIT), and will be reviewed in supervision. All contacts and attempts to contact will be documented accordingly.

a. Planned strategies to locate/engage with Assigned Enrollees with complex LTSS needs
All information regarding an Assigned Enrollee received by BLTSSCP, either through the ACO/MCO's Comprehensive Assessment or other referral information, will be utilized for outreach and engagement efforts. In addition to contact information, knowledge regarding language or communication needs and/or preferences will facilitate outreach efforts. BLTSSCP's first contact with an Assigned Enrollee will consist of an introductory telephone call by the LTSS Care Coordinator with two purposes: 1) to provide a brief overview of the role of the Community Partner, 2) to schedule a time and location for a face to face meeting. From experience, BLTSSCP has learned that for some individuals, it is more effective to call early in the month before Safe Link phone minutes are used. Initial telephone contact will be followed by a mailing to the Assigned Enrollee, inclusive of a brochure describing Long Term Services and Supports and the role of BLTSSCP (as developed and approved by EOHHS), confirmation of the scheduled follow up meeting and contact information of the LTSS Care Coordinator should an Assigned Enrollee have any follow up questions. It is also important to have call handling procedures to ensure that when an Assigned Enrollee does call BLTSSCP for any reason, appropriate staff are available to engage the individual. At each step, verbal and written communication needs, translations or interpreting will be accommodated either by BLTSSCP staff or by arrangements with other resources.

Collaboration and information sharing among health and social service providers are essential elements in order to identify communication and connection pathways. In the event that the Assigned Enrollee cannot be reached through the mechanisms described above, the Care Coordinator will call upon family members, other health care and service providers in the Assigned Enrollee's care network to obtain new or updated contact information and/or assistance in connecting with the individual. For any Assigned Enrollees who is known to be homeless, BLTSSCP will network with local homeless shelters, homeless outreach teams, homeless services, and drop in centers in an effort to connect with the individual. BLTSSCP will make a minimum of three attempts to contact an Assigned Enrollee, including at least one attempt to contact the Assigned Enrollee in person, unless the Assigned Enrollee prefers to meet only by

phone. All contacts and attempts to contact will be documented in the BLTSSCP secure electronic health record within the Care Coordination Information Technology (CCIT) and include the date of contact or attempt, mode of communication or contact, identification of the person contacted, results of the contact, and the initials or electronic signature of the LTSS Care Coordinator or other staff making the entry. If all of these outreach strategies prove to be unsuccessful, BLTSSCP will utilize a resource with which Vinfen has had success, the National Change of Address service of the US Postal Service.

Both clarity of information regarding how this program will benefit the Assigned Enrollee and the identification and use of the appropriate mode of communication are imperative in order to successfully engage with the Assigned Enrollee. Cultural, socioeconomic, environmental and other factors must also be acknowledged as factors in engagement. BLTSSCP Members will benefit from their collective cultural knowledge and language capacities. A database of these resources will be maintained through BLTSSCP and available to all Member staff. An Enrollee Engagement Library of Best Practices database will also be developed in order to document and share expertise.

The initial information to be provided to and reviewed with the Assigned Enrollee will include:

- A definition and explanation of Long Term Services and Supports
- Functions of the CP Care Coordinator and benefits of receiving LTSS CP supports
- The option for the Assigned Enrollee to choose to receive or not to receive these supports
- Information with regard to requesting a different Care Coordinator within BLTSSCP or a different LTSS CP from BLTSSCP should an Assigned Enrollee decide to enroll in the LTSS CP program
- The process for enrolling in the LTSS CP program
- The purpose of the participation form that the Assigned Enrollee will be asked to sign if the Assigned Enrollee chooses to participate, as well as the Protected Information (PI) the Contractor intends to obtain, use and share in the provision of LTSS CP Supports

Upon the Assigned Enrollee's decision to participate, the LTSS Care Coordinator will obtain a signed LTSS CP participation form and written authorization for the use and disclosure of PI as necessary in the provision of supports. These will be maintained in the Enrollee's record and LTSS care planning will be initiated within 5 days. It is likely that some Assigned Enrollees will have Legal Guardians or other authorized representatives. In those cases, all explanations of the above material will include the Legal Guardian and signatures of agreement and authorization will be necessary from the Legal Guardian. In other cases, the Assigned Enrollee may be more comfortable with or require the assistance of family or others to engage with the LTSS Care Coordinator. Every accommodation will be made to ensure that this occurs with the request and approval of the Assigned Enrollee.

2. LTSS care planning

The LTSS Care Planning process is a crucial step in the development of an effective partnership between the Enrollee and their LTSS Coordinator. This collaborative process will promote informed choice, will draw upon existing SDH and LTSS services and providers that assist an Enrollee in meeting both LTSS and SDH needs, will reflect an Enrollee's strengths, challenges, interests and goals as well as their accommodation needs.

The LTSS Care Plan (Plan) will be developed consistent with requirements of Section 2.3.A .2 of Attachment A. The Plan will be in writing, unique to each Enrollee, and will be documented in the format required in Section 2.3.A.2.d. The Plan will reflect the preferences, goals, strengths, need and cultural considerations of the Enrollee, and will incorporate the results of the ACO/MCO's Comprehensive Assessment as well as any other assessments conducted for social services including, as appropriate, Flexible Services. The Plan will also reflect any new need area an Enrollee may have developed since the time of their initial Comprehensive Assessment. The Enrollee's ACO/MCO care team will be informed of any such change. The Plan shall be approved and signed by the Enrollee or their authorized representative if any, shared and approved by the Enrollee's PCP or PCP's designee, shared with parties who need the LTSS Care Plan in connection with their support including members of the Care Team and other providers, prepared in alternative formats and/or in the Assigned or Engaged Enrollee's primary language as needed.

The development of the LTSS Care Plan and approval and signature of the Plan by the Enrollee or Authorized Representative will all occur within 90 days of the Assigned Enrollee's referral to BLTSSCP. At that time the completed Care Plan will be submitted to the ACO/MCO for approval by the PCP and, once approved, will be provided to the now Engaged Enrollee in an appropriate format.

a. Describe how you will ensure that the Enrollee has meaningful participation in the development and management of the LTSS Care Plan

The Assigned Enrollee and/or any authorized representative(s) will receive necessary assistance and accommodations throughout the entire Outreach and Care Planning and Coordination Processes. Any planning meetings and/or discussions will be scheduled to conform to the Assigned Enrollee's availability for time and/or location.

As early as the first Outreach meeting with the Assigned Enrollee, BLTSSCP Care Coordinators will begin the process of educating the Assigned Enrollee about LTSS and about the Care Plan process. Beginning with the Comprehensive Assessment results from the ACO or MCO, information will be gathered, and options discussed and reviewed with the Enrollee, options as related to their needs, desires and obstacles driven by medical, physical, or social determinant of health needs. Within 5 days following the documented decision of the Assigned Enrollee to participate in LTSS CP, the LTSS Care Coordinator will be confirmed or assigned, as needed, and the Care Planning process will be initiated. The LTSS Care Coordinator will inquire about any Legal Guardian or Authorized Representative who should be involved in the process, and who, if anyone else, the Enrollee would elect to have as part of the planning process. Information will be provided regarding self-directed care options and the assistance available.

Successful LTSS care planning begins by engaging the Enrollee in a discussion of his or her needs, goals, strengths, resources, and the services and supports he or she considers important to quality of life and health. It is critical for the LTSS Care Coordinator to hear this from the Enrollee in his/her own words before moving on to other contacts and more structured planning. The Enrollee is the expert in what the Enrollee needs and must have the opportunity to express this in language that is meaningful to him or her. The key elements of the discussion as expressed by the Enrollee then become the guiding principles of the Care Plan. Management of the Care Plan is a shared endeavor among the entire Team, as led by the Enrollee. In the

framework of Person Centered Planning, Care Team members will be chosen by the Enrollee and may include family, friends, caregivers, health care providers, clinicians, and any additional members selected by the Enrollee.

The Engaged Enrollee will be fully apprised of the ability to request a review of the Care Plan at any time and that the Care Plan must be reviewed, revised and approved every 12 months or more frequently if there is a major change in functioning.

b. Describe protocols for providing informed choice of LTSS programs and providers as part of LTSS care planning

As part of the process of the development of a Care Plan, the Comprehensive Assessment will be the starting point in providing focus as to the Enrollee's needs. Upon discussion with the Enrollee, and their signed agreement to discuss with other parties, the LTSS Care Coordinator will initiate discussions with family members, authorized representatives, health care providers, and other team members. Additional needs may arise for health care or relative to social determinants of health. The LTSS Care Coordinator will have the responsibility to identify services or supports that will meet these needs, including the status of eligibility or other funding mechanisms. The Care Coordinator will ensure that the Enrollee is informed that any recommended LTSS are subject to MassHealth medical necessity criteria and utilization management requirement and my require prior approval. If options are not readily apparent, the Care Coordinator will perform research including reaching out to other BLTSSCP Entities and their staff as well as other service providers, community resources and social service organizations to generate information. As new resources are identified, these will be shared through the BLTSSCP Learning Collaborative to develop a BLTSS Resources Directory of available community health and social service resources for specific geographies and populations, and ensure Care Coordinators have access to this Directory. Options will be presented to the Enrollee along with a thorough discussion, explanation, and comprehensive review of relevant written information to fully inform and support the Enrollee in making a decision. A minimum of two options will be identified and presented for each need. The Enrollee may choose to have family members or others present during the presentation of options. Language and culture needs will be important factors both in researching, identifying and presenting options. Standardized documentation will be completed by the Care Coordinator relative to the needs, who has identified each need, the options that were presented to address each need, the method and date of presentation, who was involved in any discussion, and decisions that were made.

3. Care team participation

a. Describe promotion of integrated LTSS communication across all stakeholders, and exchange of essential documentation as part of participation on Enrollees' care teams

Beginning with the contract award, the BLTSSCP Management Team will schedule planning meetings with ACO/MCOs to promote integrated communication across all stakeholders, and integrated care for the Enrollees. Protocols and procedures specific to effective communication and exchange of information, particularly of electronic information, will be developed and implemented across all stakeholders. These protocols will then be shared within meetings with health care providers, service providers and community resources. Agenda items will include a review of the scope of the provision of LTSS and information regarding BLTSSCP and contact

persons, LTSS Care Coordinators and the Care Plan process and processes for effective communication and shared information. For instance, it will be imperative that all members of the Care Team are provided up to date and accurate information for communication. Given the agreement of the Enrollee, the LTSS Care Coordinator will initiate contact with all known health care, service providers and other resources to gather information regarding the needs of the Enrollee as well as any past or present supports. The organization of the Team will promote open and consistent communication both formally and informally. The LTSS Care Coordinator will document all contacts and will work to ensure that information is shared in a timely manner with all Team members. As part of the Care Planning process, the LTSS Care Coordinator will develop protocols specific to the Enrollee as to how and when information will be shared among the Team members.

In response to the needs or preferences of the Enrollee, communication styles and necessary supports for effective participation by the Enrollee will be addressed at the outset of the Care Team formation. The first responsibility of the Team is to fully engage and listen to the Enrollee after which the Care Team members may offer suggestions about how the Enrollee's goals might be met. Recommendations by the health care team will be considered and discussed. The LTSS Care Coordinator and the entire Team will ensure that the orientation and dynamic of the Team is person centered, supportive, and respectful of the Enrollee's individuality and lifestyle choices, and that the plan developed reflects the desires of the Enrollee.

As directed by the Engaged Enrollee, the LTSS Care Coordinator will participate as a member of the Engaged Enrollee's ACO/MCO Care Team in order to support the Engaged Enrollee's LTSS care need decisions and LTSS integration in the Engaged Enrollee's ACO/MCO care plan as specified in Section 2.3.A.3 of Attachment A.

b. Describer how you will provide LTSS expertise and advocate for appropriate LTSS and care as part of the Engaged Enrollees' care team

BLTSSCP will work with each ACO/MCO to ascertain their preferred model of care and vision as to how best to incorporate the functions required of a community partner. LTSS Care Coordinators will be well educated in the delivery of LTSS and trained in MassHealth expectations and requirements. As such, LTSS Care Coordinators will bring both expert knowledge and vast LTSS resources, including those in the BLTSSCP Directory of Services, to the ACO/MCO Care Team serving as an expert consultant to the Care Team. The combined expertise of the Members is vast, and the internal network to share a knowledge base of resources will be well developed through the Learning Collaborative and other resource sharing mechanisms. LTSS Care Coordinators will be trained to see their role as part of this sharing network.

The long- standing focus of BLTSSCP Members on the encouragement of self advocacy in their respective service systems will provide LTSS Care Coordinators with the skills and support to work with Assigned and Engaged Enrollees to develop these skills.

4. LTSS Care Coordinators

The LTSS Care Coordinator is situated at the juncture between systems and the Enrollee, and has as a responsibility to mitigate of the effects of fragmentation that can occur in social support and health systems. Income supports, housing, health and wellness, LTSS, the role of informal supports, recovery and behavioral health all contribute to a person's overall welfare and quality

of life. Within the domain of LTSS itself, the LTSS Care Coordinator is responsible to ensure that choices in services are presented, that the services presented can achieve their objectives and are high quality. Depending on the resources and capabilities of the Enrollee, the LTSS Care Coordinator may find it necessary to assist with accessing the services in the Plan, resolving complaints, advocating on behalf of the Enrollee, scheduling services, and locating alternative services. From a systems perspective, the LTSS Care Coordinator must ensure that the services are provided with quality and continuity of care, are non-duplicative, promote integrated care, support the values of person centered planning, Community First and Principles of a Valued Life, are appropriate, and are provided in accordance with service guidelines.

The LTSS Care Coordinator is responsible for the development of the relationship with the Enrollee, gaining information regarding an Enrollee's needs and desires, playing an integral role on the Care Team, advocating when necessary, and documenting and implementing the Care Plan. The role is at the center of BLTSSCP and will be supported as such. The LTSS Care Coordinator will provide information about various options for LTSS services / programs and providers that can meet an Enrollee's needs, ensure that the needed services are authorized, assist the Enrollee in navigating and accessing these authorized services, coordinate and facilitate communication among the Enrollee, ACO/MCO and providers, and provide ongoing monitoring and implementation of LTSS Care Plan to ensure LTSS are relevant and appropriate. The LTSS Care Coordinator is also responsible for ensuring that the indicated services are implemented as directed. Through monitoring the LTSS services in an ongoing way, the Care Coordinator can ensure that the service/service provider is meeting the satisfaction of the Enrollee while monitoring for any changes in status/life events that may change the Enrollee's LTSS needs.

a. Describe how you will monitor and manage status/life cycle events that may change the Enrollee's LTSS needs

The relationships BLTSSCP will develop with ACO/MCOs and Health Care Professionals will be critical to the sharing of information related to the Enrollee's LTSS needs. Plans for regular communication will be developed by the BLTSSCP management team and negotiated with each ACO/MCO. This will enhance any verbal or written communications that occur regarding particular Enrollees. The Enrollee, family, guardian, other identified contacts, and all members of the Care Team will have contact information for the Care Coordinator and will be encouraged to contact the Coordinator with any information, questions or concerns, particularly with regard to a status/life cycle event that may change an Enrollee's LTSS needs. Such needs will be tracked in the CCIT which will in turn flag the potential need for a revision to an Enrollee's Care Plan

In addition, the monthly telephone calls and quarterly face to face meetings (at a minimum) will enable the LTSS Care Coordinator to communicate with the Enrollee directly regarding any medical, physical and/or social changes. This communication is central to LTSS planning, implementation and monitoring. The understanding of the Enrollee's strengths, resources, goals and needs forms a framework for responding to changes in circumstances and evolving needs. Any emergent changes will result in action by the LTSS Care Coordinator; this may consist of communication with the rest of the Care Team through either telephone or electronic contact, a review and modification of the Care Plan, meeting with the Care Team, referral(s) to appropriate service providers or community resources, collaboration with the appropriate resource for education on a presenting challenge, and/or conversations with family members or identified

contacts. BLTSS CP will also have the capacity to initiate an internal Risk Team process to immediately develop plans to access the appropriate resources if indicated by the information received.

b. Describe how you will support and encourage Enrollees' ongoing engagement in their care planning and implementation of their care plan. Include strategies related to motivational interviewing and promoting self-determination

BLTSSCP actively promotes self determination, independent living, consumer control and self advocacy for Enrollees and each Member, independently and collectively in this endeavor, is committed to these principles. As such, Members will draw from their existing staff training curriculum that includes Motivational Interviewing, Self Determination and Self Advocacy when training new hires for the role of LTSS Care Coordinator. The utilization of motivational interviewing is closely related to the goal of self-determination as both are person-centered and support the person to direct their goals and decisions. This will be at the core of the partnership Care Coordinators will form with Enrollees and will inform both in the development of the Care Plan and the implementation of LTSS.

Recipients of MassHealth, particularly those in need of LTSS, often have a history of being disempowered through poverty, difficulty accessing care, discrimination on the basis of a disability or language/culture, or changing circumstances. Each Enrollee of BLTSSCP will be supported and encouraged to assume responsibility for care to the greatest extent possible. To realize this goal, the LTSS Care Coordinator will first ensure that communication is designed to address any cognitive or linguistic needs, and then support the Enrollee in identifying strengths and areas of need, in expressing preferences and goals, and in making decisions about care. LTSS Care Coordinators will respect the dignity of risk and not undermine the Enrollee's autonomy while at the same time making certain that all options, challenges, risks and ramifications are fully explained and understood. Through the techniques of motivational interviewing, the LTSS Care Coordinator will use active listening to help the Enrollee explore changes without persuading or giving advice. The LTSS Care Coordinator will work in partnership with the Enrollee, supporting the Enrollee to develop and enhance their motivation to explore change and options.

5. Support for transitions of care

a. Describe your plan for providing informed choices in regard to LTSS programs and providers to Enrollees as part of transitions and how you will ensure supports are in place to enable successful transitions of care

Transitions of care can present significant challenges, particularly when exacerbated by inadequate communication and coordination among providers and systems of care. By definition, a person has experienced an adverse health event, which may also diminish the capacity to self advocate. Hospitals, rehabilitation centers, primary care, home health agencies and other LTSS providers have objectives and operating systems that may have inherently conflicting limitations, regulations, payment rules, and others. Successful transitions require the participation of all Care Team members as well as early, consistent, and active communication with the Enrollee, family members, informal and formal caregivers.

The Enrollee may require assistance from the LTSS Care Coordinator as an advocate; for example, if the Enrollee prefers to return home rather than be admitted to a nursing facility. The

LTSS Care Coordinator, in maintaining contact with the institution currently providing care to the Enrollee, will engage in discussions with staff, the PCP and other providers regarding the Enrollee's health status and post-discharge recommendations including any appointments and medications. The LTSS Care Coordinator will provide community expertise to the Enrollee's ACO/MCO, or applicable provider, to facilitate transitional care management and follow-up. The LTSS Care Coordinator will assist in developing an appropriate discharge plan and will attend the discharge meeting when at all possible. The LTSS Care Coordinator will make revisions to the Care Plan and inform all other Team members of these revisions. When an Enrollee is to return home, the LTSS Care Coordinator should be informed in advance of the date of return so as to ensure that LTSS services are or can be put in place. The Care Coordinator may need to research and present options of a new service to an Enrollee, and then coordinate the new service prior to discharge. Enrollee choice is fundamental to these decisions and activities. With early planning, at times natural supports can be explored and developed; for example, a family member could be trained to be an active caregiver.

b. Describe steps to be taken to ensure Enrollee's stability and satisfaction post-transition
The LTSS Care Coordinator will meet in person with the Enrollee within three business days of discharge, or as early as next day if the Enrollee's situation may complex to that the Care Coordinator can ensure any unanswered questions about the Enrollee's home environment or resources are addressed effectively and timely. The LTSS Care Coordinator will review changes to the Care Plan, ascertain the status of services and supports, and determine with the Enrollee if additional services, supports, or flexible services might be needed. If any changes are desired or indicated, the LTSS Care Coordinator will assume that responsibility to research and facilitate any changes possible.

It is important that the LTSS Care Coordinator maintain contact with other members of the Care Team during this post-transition period to ensure for continuity of care and promote stability. Alterations in routine, support and setting may have an effect on the Enrollee's health and/or ability to function in the new environment. This will give the Care Coordinator the opportunity to evaluate the success of the transition as well as the Enrollees satisfaction with the care transition and subsequent services implemented to ensure safety and stability of the Enrollee. The Care Coordinator will solicit feedback. Any concerns on the part of the Enrollee, family, caregivers, health care and LTTS providers and others will be shared accordingly and resolved as quickly as possible. The LTSS Care Coordinator's role will include maximizing communication strategies among these parties by developing a plan individualized to each situation.

6. Health and wellness coaching, including but not limited to:

a. Describe health and wellness education, coaching and health promotion programs or activities that will offered to Enrollees; any use of programs that are evidence-based
Health and wellness education is a multi-layered process with both the ACO/MCO Care team having a role and the LTSS Coordinator having a role. An Enrollee's ACO/MCO treatment plan will identify medical and health goals. In relation to those specified goals, the LTSS Care Coordinator will provide an Enrollee with fundamental training. In situations where there may be caregivers and/or family members who, with the Enrollee's agreement, can and will be brought into this educational process, they will be trained by the LTSS Care Coordinator as well. Following the initial training process of disease facts and prevention, a more in-depth,

personalized training will be completed as needed to assist the Enrollee and others in understanding the current health issues and prevention of new illness.

Community-based programs, both in house and as provided by other organizations, will be used as much as possible for issues such as weight control, smoking cessation, substance use, as well as support and self advocacy groups. Members offer groups for weight loss, diabetes management, PTSD management, DBT support, and provide 1:1 education when needed for such topics as diabetes management, sex education/birth control, and exercise/stress relief/weight management. The curricula used are evidence based practices and resourced through professional training literature. Member Nurses can be available, as needed, to consult with a Care Coordinator and/or with an Enrollee and provide 1:1 education on more complex medical options with the goal of reducing an Enrollee's anxiety and empowering an Enrollee to make a more informed decision about treatment.

Given that health coaching and information regarding symptom management to enable the Enrollee to be knowledgeable in the prevention and/or management of chronic medical conditions is so essential, this will be a particular focus of LTSS Care Coordinators. Education on how to reduce high risk behaviors and health risk factors such as smoking, inadequate nutrition and infrequent exercise as well as providing the assistance in accessing the concomitant health promotion activities will be provided to promote the achievement of health and wellness goals. Assistance offered by the LTSS Care Coordinator to the Enrollee in setting and meeting will promote positive health outcomes and more integrated care. Facilitation of both consistent and event based communication among health care entities such as the PCP and staff and the rest of the Team will be a crucial role of the Care Coordinator to support and educate regarding any specific and emergent health issues or concerns.

BLTSSCP Members have extensive experience in health and wellness promotion. We note in particular that MVES has been a long time member of the Healthy Living Center of Excellence (HLCE) network which advances evidence based health care promotions in the community. In the last year alone, MVES provided over 25 programs at diverse community sites as well as traditional health care delivery locations. Some of the topics covered are: Chronic Disease Self-Management, Diabetes Self -Management, Matter of Balance, Healthy Eating, Powerful Tools for Caregivers, and Chronic Pain Self-Management. MVES looks forward to expanding these successes to integrate additional Chronic Disease Self –Management Program and other support programs including Better Choices Better Health, Enhanced Wellness and Healthy IDEAS for Depression Management into the LTSS system.

7. Connecting Enrollees to social services and community resources

a. Describe evaluation of social services needs for Enrollees and facilitation of access to Flexible Services for Enrollees - include proposed screening tool the Bidder intends to use

As a component of the intake and care planning process, the LTSS Care Coordinator will become knowledgeable about the factors affecting the health needs of the Enrollee. These include social determinants of health as well as the maintenance of health supports and working toward a healthy or healthier lifestyle. A structured assessment of social service needs will occur early in the care planning process. Questions relevant to the social service needs of the Enrollee will be posed to the Enrollee as well as to collateral contacts who are part of the care planning process. Our goal is to ensure that Enrollees are informed of and are able to access all public

benefits for which they are eligible and for which there is a need such as income supports, housing, fuel assistance and utility protection, SNAP and access to food pantries, veterans' benefits, and Safelink and phone discounts. These and other local community resources will become part of the Care Plan and will be discussed with the Enrollee both at the time of the Social Assessment and at regular intervals. Enrollees will be assisted by the Care Coordinator and/or others on the Care Team as necessary to enroll in and access these resources and to approach the Enrollee's ACO/MCO Plan with any appropriate request for Flexible Services. As noted previously, BLTSSCP will establish and continuously update Resource Directories which Care Coordinators can access to select appropriate services to offer to Engaged Enrollees.

In addition, LTSS Care Coordinators will be attuned to needs for assessments of Independent Living Skills, communication, sensorimotor skills, behavior, physical and occupational therapies, social and affective development. Deficits in any of these areas can impact significantly on quality of life, health and community tenure. The Care Coordinator will focus on working with the Enrollee, the PCP / ACO Plan, MassHealth and the health care community regarding referrals and prior approval for assessments that are indicated. Please see **Attachment 3** for the draft Social Assessment that will be submitted to EOHHS for approval for use by BLTSSCP.

b. Describe how you intend to ensure ongoing connections to community resources and social services.

The connections that are established with community resources, home care programs and social services will be consistently evaluated for effectiveness, practicality and feasibility by the Care Coordinator and others on the Care Team. We will also invite resources to participate in our Learning Collaborative in order to sustain ongoing connections and promote effective collaborations. As part of our ongoing LTSS CP service, we will frequently inquire of an Enrollee and their Care Team new LTSS and SDH resources of which they may be aware so that we are expanding our network in an ongoing way. Whether related to health and healthy lifestyle, housing, income, food, spiritual needs, or social needs, the only way these resources are beneficial is with the Enrollee agreement and their follow through. As such, evaluation as described above is imperative. If a link is not working, this will be re-visited and resolved, either by making an adjustment to the current service or seeking another to address the presenting need.

BLTSSCP's familiarity with the population to be supported as well as with resources in the communities we support, both in conjunction with our own internal networks, positions us to maintain a substantial network of community and social services resources that will in turn provide choice for Enrollees. Likewise, the depth of existing partnerships all BLTSSCP Members have with a variety of state agencies, as described in earlier sections of this proposal, will serve BLTSSCP well in promoting ongoing collaboration and coordination of services for Enrollees through this innovative Community Partner program.

7.5 D Innovative Technologies

Since 2011, BLTSSCP Members Vinfen and Bay Cove, have partnered in several projects evaluating the potential contributions of innovative technologies in improving the health of people with disabilities and in reducing health care costs. All of the technologies noted below are applicable to individuals who have the capacity to use adaptive devices and learn self-management to improve health and independence.

- Vinfen and Bay Cove have deployed MedMinders with the goal of 1) helping clients take their medications on time and 2) reducing unnecessary visits by Visiting Nurse Associations (VNA). Pharmacies pre-package medications in trays, and an RN inserts and locks the trays in the MedMinder device which alerts the user to access medications at the appropriate time. Data is fed to an internet based dashboard for staff. The program, as implemented at Vinfen, has resulted in a 15% reduction in VNA spending.
- In a Behavioral Health Home program as funded by a three-year CMS Innovation Grant, Vinfen and Bay Cove embedded nursing and outreach staff into existing community-based care teams. The Behavioral Health Home clients were also provided with a Health Buddy, remote patient monitoring technology developed by Bosch. The results of the combined intervention significantly reduced Emergency Department visits as well as psychiatric hospital days. The program was evaluated by Stephen Bartels, M.D., of the Dartmouth Institute.
- Bay Cove and Vinfen are working with the Dartmouth Institute in a 5-year, NIMH-funded study to understand the benefits of deploying Phillips Telestation for use by clients living with disabilities. At the 2- year point, (with approximately 50% of the intervention group enrolled), Emergency Department visits and hospital days for the Telestation group are at rates equaling about one-third of the control group.

Outside of the above mentioned joint projects, Vinfen is launching an evaluation project with Mozazz, a company which has developed a system to support individuals with I/DD, autism and other cognitive challenges in communicating and managing their behavior and health. This system has shown significant promise in improving functioning and community tenure for these populations. Additionally, JRI uses a software called Basecamp to help facilitate community connections and improve access to information and communication among a wide range of community constituents.

In the LTSS CP program, BLTSSCP will use several types of technologies. As discussed in **Section 7.4**, all LTSS Care Coordinators will be assigned a laptop computer, will use a smart phone and will document in BLTSSCP's Care Coordination Information Technology (CCIT). In addition, BLTSSCP is committed to evaluating and pilot-testing the technologies noted above which have the potential to improve Enrollee self-management and reduce Emergency Department visits and inpatient costs. BLTSSCP has had preliminary discussions with a few ACOs about adoption and funding of innovative technologies in the LTSS CP program. BLTSSCP will evaluate technologies which have the following characteristics: address neurocognitive challenges and/or complex medical conditions; cost $50-60 PMPM, which means they are cost-effective if they save one Emergency Department visit per year and/or one hospital day; and have robust data systems which can be integrated with CCIT systems. BLTSSCP will propose use of selected technologies to ACO/MCOs to pilot-test with 10 to 20 Enrollees and is prepared to implement them should funding be available through ACO/MCO arrangements.

7.3 H Sustainability

Describe plan to sustainably fund proposed infrastructure and capacity building investments and CP Supports over the Contract Term and after the initial Contract Term. Include description of any tools, resources, or processes the Bidder intends to develop using DSRIP funds and continue to maximize after the initial Contract Term

BLTSSCP will use DSRIP funds to develop important capacities and infrastructure necessary to operate an LTSS CP program. The capacities and infrastructure that BLTSSCP develops will serve to sustain the program throughout the 5-year Contract Term and after. Certain investments will be tangible: a system to support care coordination, a data warehouse, and marketing materials including a website. Other investments will develop capacities: a workforce that is trained in LTSS Care Coordination; workflows for coordinating care across LTSS CP and ACO/MCO care teams; and a new organization that brings together seven leading Community Based Organizations into a structured collaboration –Boston LTSS Community Partners (BLTSSCP). Below are specific capacities and structures that BLTSSCP will develop to live beyond the 5-year term of the Contract:

- **ACO/MCO relationship development**: As described in **Section 7.5.J**, BLTSSCP will invest staff resources to develop relationships with ACO/MCOs in our service areas. The relationships needed to coordinate care for Enrollees go beyond a simple contract. BLTSSCP will develop, in collaboration with each ACO/MCO, specific protocols, workflows, policies and procedures to address the various areas of collaboration including: Enrollee referrals, notification of admissions, discharges and ED visits, Flexible Services processes, EHR data sharing to complete an LTSS care plan, service arrangement and authorization protocols, and transitions of care.
- **Marketing to ACO/MCOs** – BLTSSCP believes that the most important marketing work with ACOs/MCOS is the above-described relationship development work. In addition, BLTSSCP will conduct trainings for ACO/MCOs, and will create written materials.
- **Organizational structure to facilitate the collaboration of seven Members**: Each BLTSSCP Member has invested and will continue to invest the time of key personnel of its Executive and program teams to agree to a governance structure, operating agreement and key administrative functions in support of the LTSS CP program. Each Member has also devoted project management, business development and administrative staff to develop the BLTSSCP structures and policies.
- **Workforce Development** - BLTSSCP Members have existing workforces that perform LTSS care coordination responsibilities through One Care Health Homes, SCO, One Care LTSC and programs for people with I/DD. An additional 14 LTSS Care Coordinators will be recruited by Members and trained to support the LTSS CP program.
- **Training curriculum**: BLTSSCP will invest in the development of training curriculum for all BLTSSCP central and care team staff. LTSS Care Coordinators will be trained in all LTSS CP required elements. Some elements will be delivered by each respective Member and some elements that are unique to the LTSS CP program will be delivered centrally by BLTSSCP central staff.

- **Enrollee Engagement:** Success of the program will be determined in part by LTSS Care Coordinators' successes in engaging Enrollees. In addition to staff training and coordination with ACOs, BLTSSCP will invest in the following Enrollee engagement strategies: development of an Enrollee Engagement Library of best practices, and marketing materials for Enrollees. Most important is the investment to each Member organization to support the hiring of LTSS Care Coordinators in advance of having full caseloads. Although Enrollee engagement will be required throughout the Contract term, more Engagement work will be required in the first two Budget Years to reach BLTSSCP's Enrollment Capacity.
- **Resource directories and networks of community-based organizations:** BLTSSCP care teams will build on existing community-based networks to develop directories of LTSS and social service providers for the LTSS CP program.
- **Care Coordination Information Technology (CCIT) and Data Warehouse systems:** BLTSSCP will select, configure and develop a specialized care coordination system for the LTSS CP program. The CCIT will be used by all CC/CCMs to perform care management functions. It will also be used by financial, quality and programmatic staff to manage the performance of the program. The CCIT will be supported by a Data Warehouse that will store LTSS CP Enrollee data and will allow for aggregation of other data such as EHR data from ACOs and/or claims data from MassHealth and/or MCO/ACOs. DSRIP funds of over $150,000 over the five Budget Periods and the Preparation Budget Period will be spent on Information Technology solutions to support the development, implementation, and sustainability of the program.

Except where otherwise noted, all above described capacities and infrastructure will be supported through the investment of DSRIP funds. Some investments occur in the first few months of the program and other investments require sustained management over the five years of the program with less funding required to sustain after the LTSS CP Contract term. For example, Information Technology requires an up-front investment of over $65,000. These costs are capitalized and spread across the five year Contract term. On an ongoing basis, BLTSSCP's Program Budget proposes spending $30,000 per year to manage the IT systems which includes the cost of user fees, and funding to support a User Support Specialist and Systems Administrator. Another example is the ACO/MCO relationship development work. In the Preparation Period and Year 1, the Executive Director, Deputy Director and LTSS Program Manager will be dedicated to documenting workflows, protocols, policies and procedures with ACO/MCOs but in later years as the LTSS CP program is more established, those staff will focus on contract management and program improvement work.

The DSRIP investments are detailed in Section 7.5.G Budget and Budget Narrative. BLTSSCP's Budget proposes investments in infrastructure in the first few years. In later years, the base PMPM subsidizes more of the administrative functions needed to sustain the program with less support required from DSRIP funds. Sustainability of the LTSS CP program beyond the Contract Term will ultimately depend on BLTSSCP's relationships with ACO/MCOs, whether the services that BLTSSCP has provided lead to better health at reduced costs for the highest cost ACO Enrollees, and if so, whether ACO/MCOs will invest in this service moving forward.

7.5 I Quality Management and Perfromance Monitoring

1. Describe Bidder's quality improvement program

BLTSSCP will leverage Members' years of experience managing robust Quality Management (QM) systems to develop and implement quality improvement programs targeting the health domains in the new LTSS CP program. Each Member employs QM systems which include: annual objectives derived from organizations' mission, long term goals, environmental scans, and needs identified from prior year performance; data collection across a wide range of behavioral and physical health measures, including process and outcome data across domains listed in Attachment A: Model Contract and Appendix C: LTSS Community Partner Quality and Accountability of the RFR; processes for data analyses to shape implementation, and modification of annual and multi-year initiatives to improve performance. Examples include:

- Prevention and Wellness: tracking and improving adherence to annual physical exams, and participation in wellness activities, such as walking clubs, or fitness club participation.
- Member Experience: implementing and tracking satisfaction surveys from individuals served, as well as families and guardians, and use of these surveys to develop staff training or other interventions to improve these ratings.
- Avoidable Utilization: minimizing and tracking avoidable Emergency Departmenent visits and unnecessary home health services (e.g., multiple skilled nursing visits per day for simple medication administration).
- Integration: tracking of data on both behavioral and health symptoms and utilization to develop and evaluate special initiatives in which integrated services to improve process, outcome, and value-based measures. Community tenure (healthy days in the community vs days in psychiatric or medical hospitals, or Skilled Nursing Facilities) will be measured, as this metric is increasingly recognized as a key indicator of effective integrated care and overall health.
- Engagement: tracking participants adherence to scheduled appointments, participation in and approval of person-centered treatment plans.
- Chronic Disease Management: tracking claims and metrics data and developing initiatives to improve blood pressure, weight and BMI, and management of diabetes with tracking of A1c levels.

BLTSSCP's Quality Improvement (QI) Plan will be developed with the participation of the Member organizations, and input from partnering ACOs/MCOs, and will be submitted to EOHHS for approval prior to implementation. The QI Plan will be implemented and evaluated monthly by each Member and BLTSSCP's Quality Management (QM) Committee for the first year; then, if trends are stable, quarterly thereafter and throughout the Contract Term. The QI Plan and reports on required Quality Metrics will be submitted to EOHHS on an annual basis. Members' organizational leadership including Quality Managers and Care Team staff will be responsible for collecting data and implementing initatives. Adherence to the plan will ensure that BLTSSCP is providing services that meet the expectations of Engaged Enrollees, of partnering ACO/MCOs, and the requirements of Masshealth and CMS.

2. Description of at least one quality initiative the Bidder proposes to undertake in the first year including measures for success.

In the first year of the award, BLTSSCP will develop a quality management (QM) initiative to address *Care Coordination and Care Transitions* as these domains are essential to the success of the LTSS CP program.

While BLTSSCP has selected *Care Coordination and Care Transitions* as our primary focus for the first year's quality initiatives, another high priority for our service model will be providing support, linkages and referrals to assist Enrollees to remain in the community and avoid hospitalizations. We believe that measuring and evaluating the Enrollee's quality of care, chronic disease management, care transitions, caregiver stress, isolation, social connectedness and other social determinants of health are an integral part of the Enrollee's care and our Quality system will monitor these outcomes as well.

BLTSSCP's Quality Management (QM) Committee will define the metrics and processes for data collection, analyses, and improvement initiatives. The formal Quality Improvement Initiatives will address all required service components of Care Coordination and Care Transitions. BLTSSCP's CCIT will capture Care Coordination and Care Transitions data including but not limited to data related to the below requirements, processes, and outcomes.

Care Coordination of LTSS and LTSS-related Services: This initative will track the processes necessary for care coordination to meet requirements for completeness, timeliness and effectiveness, and will develop initiatives to correct or improve performance. An LTSS Care Coordinator will document the development of the LTSS Care Plan in the CCIT, including the timeliness and completeness of the following components: the ACO generated Comprehensive Assessment; an LTSS and social services needs assessment; presentation of choices of LTSS programs and providers; Enrollee (and/or guardian) acceptance of choices to meet informed choice requirements; explanation of MassHealth prior authorization requirements; and presentation of rights and appeal processes. The system will track both the submission of the LTSS Care Plan to the ACO/MCO for approval by the PCP or designee and the delivery of the approved plan to the Enrollee (or guardian) and will collect data on qualifying activities by the LTSS Care Coordinator, including type of contacts (e.g. telephone, home or hospital visit), date, time and content of meeting. An LTSS Care Coordinator will enter important data into the CCIT on changes in the status/life cycle of the Enrollee. The CCIT will be configured to produce alerts to indicate the need for potential revisions in the LTSS care plans based on these life changes, and will track data (as described above) on the processes and timetables for revising the plan. Finally, data from other sources, including claims data and reports from other LTSS providers, will be sought to enter into the CCIT in order for the Care Coordinator, Director of Care Coordination, and QM Committee to evaluate the provision of LTSS services to the Enrollee in accordance with the plan. Data on these LTSS care coordination processes and results will be available at the Care Coordinator, program, and BLTSSCP level, and will be reviewed by managers and the BLTSSCP QM Committee, to identify and develop initiatives to improve performance.

Transitions of Care: LTSS Care Coordinators will participate in and collect data on care transitions, such as Emergency Department visits, and admissions and discharges from acute hospital or Skilled Nuring Facility stays. Care Coordinators will also collect data on contact events such as visits with the Enrollee and telephone contacts to LTSS service providers. As with changes in life status noted above, these transitions may prompt re-evaluations and modifications in the LTSS care plans to meet changing needs of the Enrollee. Data on planned changes in LTSS services and on actual implementation, (for example, increased scheduled support from PCAs), will be tracked in the CCIT system. Data on LTSS care transition planning processes and results will be available at the Care Coordinator, program, and BLTSSCP level, and will be

reviewed by managers and the BLTSSCP QM Committee, to identify and develop initiatives to improve performance.

As claims and other outcome data become available for metrics such as community tenure and all-cause re-admissions, the BLTSSCP QM Committee will evaluate relations among LTSS Care Transitions and other data, and take steps to generate improvements in performance.

3. The functions of the Bidder's quality management committee including the composition and reporting structure within the Bidder's organization.

BLTSSCP will establish a Quality Management (QM) Committee chaired by Vinfen's VP of Quality and Compliance. Membership of the Committee will consist of the Executive Director, Deputy Director and LTSS Program Manager as well as Quality Directors of each Member organization. The QM Committee will meet monthly for the first budget period, at least quarterly thereafter and will report to BLTSSCP's Board of Directors. BLTSS may determine more frequent meetings are needed for the first one to two years of the contract. The QM Committee will be responsible for the establishment, maintenance and continuous review of the Quality Improvement Initiatives as well as the ongoing review of reports on all Quality Measures. The Executive Director of BLTSSCP will conduct monthly reviews of quality data with BLTSSCP Members' staff; engage in management actions to improve data as needed; participate in the QM Committee and report on actions taken to improve processes and outcomes as planned with the Committee.

BLTSSCP will collaborate with EOHHS, and with ACOs as needed, to establish performance benchmarks for all Quality Measures. BLTSSCP will review the Quality Score and DSRIP Accountability Score from EOHHS for each Budget Period. All Quality Measures, including the claims-based measures, chart review measures, and Enrollee experience surveys across required domains will be reviewed by the program leaders for each Care Team, Member organization, and the BLTSSCP QM Committee. Although Budget Periods 1 and 2 are "pay-for-reporting," BLTSSCP will implement improvement plans for any domain area that is trending or falls below the "attainment threshold," and will analyze reasons for all preventable Emergency Department visitsand all cause readmissions in preparation for Budget Period 3 when Outcomes Based Payments begin. The QM Committee will review the assigned achievement points as well as the overall Domain score in each category against the "attainment threshold" and "excellence benchmark" set by EOHHS as well as the overall Quality Score. For any domain that falls below the attainment threshold, BLTSSCP will conduct a review and determine a plan of action to implement needed improvements. Since the DSRIP score is in part based on improvements from the previous Budget Period, close monitoring of progress will be imperative to maximize possible Improvement Over Self Points. In the event that BLTSSCP does not achieve a 100% DSRIP Accountability Score, BLTSSCP will provide EOHHS with a corrective action plan that includes steps to regain any at-risk funds.

7.5 J Coordination with ACOs and MCOs

1. Describe how you will communicate your skills/expertise/value to potential ACO/MCOS

Boston LTSS Community Partners (BLTSSCP) recognizes that to be successful in serving Enrollees in the LTSS CP program, it is important to develop systems and practices to ensure coordination with ACOs and MCOs resulting in better care for people with LTSS needs. To that end, BLTSSCP Members have reached out to nearly all eleven ACO/MCO bidders in BLTSSCP's proposed Service Area (Greater Boston Region, Brockton in the Southern Region and Malden in the Northern Region) to recommend that we commence a planning process. To date, BLTSSCP Member leaders have met at least once with nine of the eleven ACO/MCO bidders. In some of those meetings BLTSSCP and ACO leaders have developed plans to conduct case reviews cases and pilot test systems. BLTSSCP views all initial ACO meetings as the first step in a longer planning process that will culminate in contracts by March 1, 2018.

BLTSSCP uses the following planning process to develop ACO/MCO relationships and contracts:

Information gathering: This phase involves as many meetings as might be indicated to 1) connect BLTSSCP program leaders with key ACO/MCO clinical and business leaders; 2) provide background information on the LTSS CP program; 3) obtain information from the ACO on projected LTSS populations; 4) and provide information on BLTSSCP's care coordination experience and approach, and current population served.

Roles, responsibilities and workflows: It will be imperative that stakeholders agree on each entity's roles and responsibilities; document workflows and points of coordination. This will be a key step in the initial planning process.

Case reviews: BLTSSCP will, with select ACO/MCO Bidders, review five to ten cases of current shared clients/patients to develop an understanding of the specific services BLTSSCP and ACO/MCO each provide and to identify service gaps, redundancies and opportunities for improved coordination.

Several Members within BLTSSCP have existing care coordination relationships with ACO/MCOs that will be the foundation for developing expanded LTSS CP programs. For example, Mystic Valley Elder Services and Somerville Cambridge Elder Services have embedded care coordinators in both inpatient settings of Cambridge Health Alliance and Hallmark Health (Wellforce ACO). In the coming months, BLTSSCP will propose pilot programs with key ACO/MCO bidders in our Service Areas. The pilot programs will serve to develop relationships between the key points of contact at BLTSSCP and ACO/MCO Bidders. This will pave the way so that contracts can be developed that accurately delineate roles and responsibilities of each stakeholder to ensure that BLTSSCP and an ACO/MCO are ready to go-live with a larger program in Spring 2018.

2. Describe branding and marketing plans you will implement with respect to your relationship with ACOs and MCOs

As described above in Section 7.5.J.1, BLTSSCP's marketing will start with meetings with ACO/MCOs, to identify the key points of contact within the ACO or MCO. Presentations for the key points of contact within the ACO or MCO will follow to ensure that all are aware of the LTSS CP program and the role that BLTSSCP plays in supporting individuals with LTSS needs.

BLTSSCP will develop its own brand, including logo, letterhead, and style templates. This brand will be used to support the in-person relationship development work. BLTSSCP will also develop the following types of media: a website, PowerPoint presentation, and succinct leave-behind materials for the key audiences at ACO/MCOs.

3. Describe your strategy to engage and collaborate with multiple ACO/MCOS in the Services Areas for which you are bidding

BLTSSCP will continue with the planning process described in Section 7.3.H.1, developing relationships with all ACO and MCO bidders in the Greater Boston Region and the Brockton Service Area in the Southern Region and the Malden Service Area in the Northern Region.

4. Describe your strategy for conflict resolution, should any conflicts arise between the Bidder and an ACP/MCO

In that the MassHealth ACO/MCO and LTSS Community Partner program initiatives bring entities together into new types of relationships, there are several areas that have the potential for conflict within this new landscape. Potential conflicts can include overlap in care coordinator roles, difference in comprehensive assessment or care plan formats, differences within the Information Systems used for documentation of care coordination activities, and different approaches to use of flexible services. The most important strategy for conflict resolution is prevention. Most conflicts arise when roles, responsibilities and expectations have not been clearly defined. BLTSSCP will invest time in developing contracts and operational relationships with ACO/MCOs prior to April 1, 2018 to avoid conflicts as much as possible. In addition, BLTSSCP will develop regular coordination meetings with ACO/MCOs to check in on our work together and will outline escalation paths for conflicts that occur in the field.

To date, we have found there to be uneven information among ACO/MCO Bidders about the LTSS Community Partner program. To the extent that MassHealth can provide all ACO/MCO and LTSS CP Contractors the same information on program design, it will prove fundamental to preventing and resolving any potential conflicts. With that said, BLTSSCP does provide ACO/MCO bidders with MassHealth LTSS CP program documents in introductory meetings as a first step to ensure that we are starting with the same program assumptions.

7.5 K Providing Culturally Competent and Informed Services and Supports

1. Describe the provision of effective, equitable, understandable, and respectful quality supports that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy, and other communication needs

Members of BLTSSCP have proven track records of internal language and cultural capacity that in turn promotes equitable, understandable and respective supports to those we serve.

a. Describe how the provision of language / communication assistance (ie. qualified interpreters) for Enrollees with Limited English Proficiency, Deaf Enrollees, Enrollees who are Hard of Hearing, and Enrollees with cognitive disabilities will be achieved

Through the collective language capacity inclusive of Cantonese, Mandarin, Italian, Spanish, Portuguese, French, Haitian Creole, Vietnamese, Greek, Hebrew, Toisanese, Cape Verdean Creole, Belorusian, Dutch, Fuzhou, German, Polish, Russian, and Ukrainian, BLTSSCP is well positioned to meet the language/communication needs of CP Enrollees. In the event that an Enrollee presents with a language need that is outside the capacity of BLTSSCP, interpreter services such as Catholic Charities' Community Interpreter Services (CIS), the AT&T Language Line and in Lingua have been and will be used to access communication support. The current provision of supports to individuals who are deaf or hard of hearing through ASL and the use of certified interpreters through Language Connections, MA Department of Interpreter/CART Services and MA Department of Deaf and Hard of Hearing will in turn serve CP Enrollees well. Other communication options include the Meyer Johnson Software (e.g. Boardmaker), use of smartphones and tablets, and voice to text capacity.

b. Describe how Enrollees will be informed of available language and communication assistance clearly and in their preferred language or format

Upon assignment of the Enrollee, the language capacity and needs as well as the need for any communication assistance will be assessed through the information contained in the Comprehensive Assessment and/or through direct contact with Assigned Enrollees. Subsequently, the resources as delineated above in **7.5 K a.** will be implemented to both inform Enrollees of available language and communication assistance in their preferred language and format and meet their LTSS needs in a manner that is equitable, understandable, and respectful.

c. Describe how the provision of supports in a manner responsive to diverse cultural beliefs and practices, including those related to an individual's race, ethnicity, disability, sexual orientation, and gender identity will be achieved

Sensitivity to cultural beliefs and practices will be a cornerstone of the relationship developed by the Care Coordinator**.** BLTSSCP's training curriculum will be designed to weave responsiveness to all diversity throughout the training wherever possible. Curricula for topics including cultural beliefs, race, ethnicity, disability, sexual orientation and gender identity as well as sensitivity training have been developed and are implemented by the Members. Linkages to community resources that have been nurtured by the Members reflect the diversity in populations currently supported. And culturally and linguistically diverse community resources will be researched through staff knowledge, internet and social resources, and community input. The Learning Collaborative that BLTSSCP intends to launch will be of assistance in sharing community resources among Member Care Teams. Ascertaining cultural beliefs and practices of an Enrollee will be a component of the outreach to the Enrollee. This information will be used by the Care

Coordinator in the interactions with the Enrollee, in the development of the Care Plan, and in linkages to resources and supports.

2. Describe the expertise and experience in providing care to special populations, including but not limited to following

a. Individuals experiencing homelessness
Members of BLTSSCP have experience supporting people who are homeless or who are at risk of experiencing homelessness. Bay Cove operates ten apartments for chronically homeless Individuals who have Developmental Disabilities, a specialized Adult Day Health program for homeless individuals as well as a Day Shelter for homeless elders, and a Night Shelter in Boston with a capacity of 80. JRI's Youth Harbors Program works with school aged, homeless youth who are without family support to locate safe and temporary housing while working with the youth toward permanence.

b. LGBTQ populations
Members of BLTSSCP have experience supporting LGBTQ populations. JRI provides LGBTQ-specific mentoring, housing, and education supports, and provides services through a center for LGBTQ+ youth. BSHC, MVES, and SCES meet the needs of LGBT elder adults through collaboration and consultation with the LGBT Aging Project. And SCES connects people to LGBT meal programs across service areas.

c. Criminal Justice-involved individuals
Members of BLTSSCP have extensive experience working with Individuals who have been involved in the criminal justice system. JRI provides mental health evaluation, consultation, liaison and care planning services for court-involved youth through Juvenile Court Clinics and Juvenile Resource Centers under contract with the Juvenile courts. JRI also provides services to court involved youth through the Boston based SMART Team. Bay Cove and Vinfen provide services to Individuals with I/DD who have a history of court involvement and who require services with a forensically based specialization.

d. Individuals who are blind, low vision, Deaf or hard of hearing
BLTSSCP Members provide supports to individuals with vision and/or hearing needs. Bay Cove and Vinfen provide residential services to individuals who are deaf and communicate with ASL or adaptive technology. Likewise Day Habilitation programs of Bay Cove, JRI and Vinfen provide specialized supports to blind, low vision, deaf, or hard of hearing Individuals through Perkins assessments and accommodation, and assisted technology. Each of these programs hire and train ASL staff to ensure that individuals experience a safe and comfortable environment.

e. Individuals with cognitive disabilities
BLTSSCP Members provide an array of services and supports to individuals living with cognitive disabilities and are attuned to communication techniques that are most effective with these individuals, including clear presentation of information followed by consistent and frequent review. Bay Cove, JRI and Vinfen provide day/employment, residential and family support to adults and children with a range of cognitive disabilities, including I/DD and ABI populations, while BCIL, BSHC, MVES and SCES support individuals who present with cognitive disabilities in addition to physical and/or aging needs.

Community Partner Program Budget Report

Massachusetts Care Coordination Network

Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Estimated Enrollees- Start of Period (All Enrollees)		250	2,000	4,500	4,500	4,500	
Estimated Enrollees - End of Period (All Enrollees)		1,750	4,500	4,500	4,500	4,500	
Estimated Enrollees - Monthly Average		1,000	3,563	4,500	4,500	4,500	
Total Estimated Program Revenue		**$ 560,000**	**$ 3,420,000**	**$ 4,320,000**	**$ 4,320,000**	**$ 4,320,000**	**$ 16,940,000**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -	$ -	$ -	$ -
Revenue for Operations		$ 560,000	$ 3,420,000	$ 4,320,000	$ 4,320,000	$ 4,320,000	$ 16,940,000

	Program Expenses		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
1	**Salary**		$ 77,083	$ 504,430	$ 2,412,000	$ 2,637,400	$ 2,643,900	$ 2,649,657	$ 10,924,470.00
2	**Fringe**		$ 16,958	$ 110,974	$ 530,640	$ 580,228	$ 581,658	$ 582,925	$ 2,403,382.54
	Total Personnel Costs		$ 94,041	$ 615,404	$ 2,942,640	$ 3,217,628	$ 3,225,558	$ 3,232,582	$ 13,327,853
3	**Training & Professional Development**			$ 39,200	$ 85,000	$ 85,000	$ 85,000	$ 85,000	$ 379,200
4	**Travel**		$ -	$ 45,563	$ 85,050	$ 91,125	$ 91,125	$ 91,125	$ 403,988
5	**Equipment**		$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	**Supplies**		$ -	$ 15,450	$ 16,269	$ 16,475	$ 16,475	$ 16,475	$ 81,144
7	**Contract Services** (consulting, professional)		$ -	$ 7,500	$ 10,000	$ 20,000	$ 20,000	$ 10,000	$ 67,500
8	**Software licensing**		$ 90,000	$ 6,000	$ 6,000	$ 6,000	$ 6,000	$ 6,000	$ 120,000
9	**Telecommunications**		$ 2,205	$ 3,920	$ 3,881	$ 71,381	$ 71,381	$ 3,881	$ 156,649
10	**Occupancy** (rent, utilities, maintenance)			$ 28,508	$ 84,678	$ 116,961	$ 116,961	$ 116,961	$ 464,069
11	**Other**		$ 6,000	$ 91,400	$ 225,600	$ 274,600	$ 288,100	$ 254,100	$ 1,139,800
	Total Direct Costs		$ 192,246	$ 852,945	$ 3,459,118	$ 3,899,170	$ 3,920,600	$ 3,816,124	$ 16,140,203
12	**Indirect Cost/Administrative Overhead**	**12.0%**	**$ 23,070**	**$ 102,353**	**$ 415,094**	**$ 467,900**	**$ 470,472**	**$ 457,935**	$ 1,936,824
	TOTAL EXPENSES		$ 215,316	$ 955,298	$ 3,874,212	$ 4,367,070	$ 4,391,072	$ 4,274,058	$ 18,077,027
	Surplus/Shortfall		*$ (215,316)*	*$ (395,298)*	*$ (454,212)*	*$ (47,070)*	*$ (71,072)*	*$ 45,942*	*$ (1,137,027)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

Community Partner Program Budget Report - Prep Budget Period

Only complete this Program Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Vice President of Seven Hills Family Service	$ 120,000.00	0.3	0	$ -
Director of Integrated Care Management	$ 100,000.00	1	6.25	$ 52,083.33
Intake/Outreach Coordinator	$ 80,000.00	1	1	$ 6,666.67
Care Coordinator Supervisor	$ 55,000.00	1	1	$ 4,583.33
Care Coordinator	$ 45,000.00	3	1	$ 11,250.00
Associate Care Coordinator	$ 30,000.00	1	1	$ 2,500.00
				$ -
				$ -
				$ -
Total Salary (Program Budget Line 1)		**7**		**$ 77,083**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 77,083.33	22%	$ 16,958
Total Fringe (Program Budget Line 2)			**$ 16,958**

Total Personnel*	**$ 94,042**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

VP of SHFS - Provide executive oversight and planning to theMCCN Director and overall integrated LTSS care management service line with a start date of November 1, 2017; In-kind $120,000 salary x .3 FTE x 7 months = $21,000 plus 22% fringe for a total of $25,620

Director of Integrated Care Management - Responsible for developing and planning MCCN's integrated LTSS care management service line across all three regions of operation with a start date of November 15, 2017

Intake/Outreach Coordinator-RN; Responsible for working with the MCCN Director to develop marketing, outreach, and engagement strategies including intake and referral process. Will be hired one-month prior to go-live for training purposes.

Care Coordinator Supervisor - Oversees team of 6 Care Coordinators and participates in providing comprehensive care coordination to Assigned and Engaged Enrollees. Will be hired one-month prior to go-live for training purposes.

Care Coordinator - Provides comprehensive care coordination activities to Assigned and Engaged Enrollees; 3 FTES – one in each region - will be hired one-month prior to go-live for training purposes.

Associate Care Coordinator - Assists a team of 6 Care Coordinator in providing care coordination activities to Assigned and Engaged Enrollees; Will be hired one-month prior to go-live for training purposes

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost

	A	B	C	D	E	F
46						
47	**Total Training and Professional Development**					
48	**(Program Budget Line 3)**					
49						
50	***Provide a description of each Training and Professional Development line item included in the table above:***					
51						
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80	**Row 4 - Travel**					
81	**Position**	**Est miles per month**	**# months**	**Mileage reimbursement rate**	**Total Cost**	
82					$ -	
83					$ -	
84					$ -	
85					$ -	
86					$ -	
87					$ -	
88					$ -	
89					$ -	
90					$ -	
91					$ -	
92					$ -	

	A	B	C	D	E	F
93					$ -	
94					$ -	
95					$ -	
96					$ -	
97					$ -	
98					$ -	
99					$ -	
100					$ -	
101					$ -	
102					$ -	
103					$ -	
104					$ -	
105					$ -	
106					$ -	
107					$ -	
108					$ -	
109						

110	Travel Expense Description	Cost
111	Total Mileage	$ -
112	Parking and tolls	
113	Public transportation	
114	Enrollee travel	
115	**Total Travel**	**$ -**
116	**(Program Budget Line 4)**	

117

118 ***Please describe how mileage estimates and other travel expenses listed above were determined . If including***
119 ***enrollee travel expenses above, please explain how these expenses will be used by enrollees.***

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136 **Row 5 - Equipment**

137	Description of Equipment	Unit Cost	#units or FTEs	Cost
138				
139				
140				

	A	B	C	D	E	F
141						
142						
143						
144						
145	**Total Equipment (Program Budget Line 5)**					

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Row 6 - Supplies

	Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
177				
178				
179				
180				
181	**Total Supplies (Program Budget Line 6)**			

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
Netsmart Licensing Fee	11250	8	$ 90,000.00
		Total Software Licensing (Program Budget Line 8)	

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

The Software and Hosted System line item totaling $90,000 is based on a monthly subscription of $11,250 that will be invoiced monthly and that is calculated based on MCCN's anticipated maximum enrollment plus the Care Manager ETL for Reporting. The $90,000 covers an eight month period, October 1, 2017 through May 31, 2018, as required by Netsmart ($11,250 x 8 = $90,000). The $11,250 will be a recurring monthly fee throughout the life of this demonstration project.

Row 9 - Telecommunications

Type of Service Plan	Cost per Service Plan	# Service Plans	Cost
Connectivity for mobile devices			$ 2,205.00
Total Telecommunications (Program Budget Line 9)			

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

Connectivity for 9 Mobile Devices (8 new staff plus 1 existing staff) @$35 P/mth for 7 month period. 9 x $35 x 7 = $2,205.00

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost
			$ -
			$ -
			$ -
			$ -
			$ -
Total Occupancy (Program Budget Line 10)			

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

Row 11 - Other

Other Direct Expense Description	Cost
Marketing Materials	$ 6,000.00

	A	B	C	D	E	F
379	**Total Other Direct Costs (Program Budget Line 11)**					
380						

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Cost to hire a consultant to design a brochure and style guide- 3 versions, 2 rounds of revisions, presentation materials, print and electronic file formats (EPS, JPG, PNG, PDF) for MCCN to be used for outreach and engagement activities -$6,000 (50 hours @ $120 p/hr = $6,000).

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead	**12.00%**	**$ 12,005.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

MCCN will charge an indirect cost/administrative overhead rate of 12% on the total PBP budget.

	A	B	C	D	E	F
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Community Partner Infrastructure Budget Report

Massachusetts Care Coordination Network

	Infrastructure Investment Funding		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
	PMPM Infrastructure Rate			$ 75.00	$ 49.72	$ 43.28	$ 36.40	$ 29.34	
	Engaged Enrollees			1,750	1,750	4,500	4,500	4,500	
	Estimated Infrastructure Funds			$ 918,750	$ 1,044,120	$ 2,337,120	$ 1,965,600	$ 1,584,360	**$ 7,849,950**
	At- Risk Withhold Rate				25%	44%	63%	81%	
	Withhold				$ 261,030	$ 1,028,333	$ 1,238,328	$ 1,283,332	**$ 3,811,022**
	TOTAL MAXIMUM FUNDS AVAILABLE		$ 450,000	$ 918,750	$ 783,090	$ 1,308,787	$ 727,272	$ 301,028	**$ 4,488,928**
	Infrastructure Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
	Technology								
1	**IT Staffing including Fringe**		$ 18,300	$ 42,700	$ 73,200	$ 81,679	$ 85,400	$ 87,840	**$ 389,119**
2	**Development Adaptation of EHR and/or Care Management System**		$ 179,154	$ 96,750	$ 135,000	$ 135,000	$ 135,000	$ 135,000	**$ 179,154**
3	**Technology for Service Delivery**		$ 7,586	$ 12,000	$ 64,488	$ 39,169	$ 39,169	$ 39,168	**$ 201,580**
4	**Other Technology Expenses**			$ 17,128	$ 17,128	$ 17,128	$ 17,128	$ 17,128	**$ 85,640**
	Total Technology		$ 205,040	$ 168,578	$ 289,816	$ 272,976	$ 276,697	$ 279,136	**$ 1,492,243**
	Workforce Development								
5	**Workforce Development staffing including Fringe**		$ -	$ 61,000	$ 61,000	$ 61,000	$ 61,000	$ 61,000	**$ 305,000**
6	**Recruitment Expenses**		$ 3,000	$ 9,000	$ 9,000	$ 9,000	$ 9,000	$ 9,000	**$ 48,000**
7	**Training Expenses**		$ 1,500	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000	**$ 16,500**
8	**Retention Expenses**		$ -	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	**$ 25,000**
	Total Workforce Development		$ 4,500	$ 78,000	$ 78,000	$ 78,000	$ 78,000	$ 78,000	**$ 394,500**
	Business Start Up Costs								
9	**Office Equipment (PBP & BP1 only)**		$ -	$ 7,500					**$ 7,500**
10	**Office Furniture (PBP & BP1 only)**		$ -	$ 42,500					**$ 42,500**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**		$ 215,316	$ 395,298	$ 454,212	$ 47,070			**$ 1,111,896**
	Total Business Start Up Costs		$ 215,316	$ 445,298	$ 454,212	$ 47,070	$ -	$ -	**$ 1,161,896**
	Operational Infrastructure								
12	**Operation Staffing including Fringe**		$ -	$ 46,258	$ 79,300	$ 154,879	$ 158,600	$ 87,962	**$ 526,999**
13	**Other Operational Expenses**		$ -	$ 97,500	$ 45,000	$ 45,000	$ 45,000	$ 45,000	**$ 277,500**
	Total Operational Infrastructure		$ -	$ 143,758	$ 124,300	$ 199,879	$ 203,600	$ 132,962	**$ 804,499**
14	**Indirect Cost/Administrative Overhead Rate**	12.0%	$ 25,145	$ 52,840	$ 59,054	$ 66,103	$ 66,996	$ 58,812	**$ 328,949**
	TOTAL INVESTMENTS		**$ 450,000**	**$ 888,475**	**$ 1,005,382**	**$ 664,028**	**$ 625,293**	**$ 548,910**	**$ 4,182,088**

Community Partner Infrastructure Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.

Lines may be added to the Infrastructure Budget Narrative tables as necessary

Row 1 - IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
IT Project Manager	$ 60,000.00	1	3	$ 15,000
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	1		$ 15,000
	Fringe rate	22.0%	Total Fringe	$ 3,300
			Total IT Staffing including Fringe (Infrastructure Budget Line 1)	**$ 18,300**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

The IT Project Manager will be responsible for working closely with the software vendor to ensure that the care management tool is developed and in compliance with the objectives of the Model Contract and MCCN LTSS CP. The IT Project Manager will coordinate MCCN IT staff training in collaboration with the software vendor and will help to facilitate a smooth implementation of the software tool with all MCCN Affiliated Partners and Material Subcontractors.

Row 2 - Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Professional Services (Non-Recurring Fee)	$ 179,154.00

	A	B
34	Software and Hosted System (Recurring Fee)	
35		
36		
37		
38		
39	**Total Development and Adaptation of EHR and Care**	
40	**Management System**	**$ 179,154.00**
41	**(Infrastructure Budget Line 2)**	
42		
43	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract***	
44	***and how the costs were determined:***	
45	Professional Services totaling $179,154 reflects a portion of the total cost required for setup and development of the Care Manager	
46	solution by Net smart. This is a non-recurring fee that is not expected to increase should Netsmart contract with a total of 5 Community	
47	Partners.	
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57		
58	**Row 3 - Technology for Service Delivery**	
59	**Description of Expense**	**Cost**
60	Computers and Mobile Devices	$ 7,586.00
61		
62		
63		
64		
65		
66	**Total Technology for Service Delivery**	**$ 7,586.00**

	A	B	C	D	E	F	G
67	**(Infrastructure Budget Line 3)**	**$ 7,586.00**					

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

This line item includes computers and mobile device for eight new MCCN staff hired during the PBP time period @ $948.25 per staff and to be used for service delivery. 8 x $948.25 = $7,586. To be purchased and distributed by Seven Hills.

Row 4 - Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses (Infrastructure Budget Line 4)	**$ -**

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 6 - Recruitment Expenses

Description of Expense	Cost
Recruitment methods for MCCN staff	$ 3,000.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 3,000.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

This $3,000 line item includes fees for job postings, advertising, job fairs, etc. , needed to recruit qualified candidates for MCCN positions in each of the three regions. $1,850 allocated to SHFS; $575 allocated to each BAMSI and Advocates.

Row 7 - Training Expenses

Description of Expense	Cost
Training methods for MCCN staff	$ 1,500.00
Total Training Expenses (Infrastructure Budget Line 7)	**$ 1,500.00**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

$300 per 5 FTE (3 CCoordinators - 1 in each region plus one CC Supervisor and one ACC) to train and orient new staff including development of training curriculum, access to online training supports, certification costs for program. $900 allocated to SHFS and $300 allocated to each BAMSI and Advocates.

Row 8 - Retention Expenses

Description of Expense	Cost

	A	B	C	D	E	F	G
199							
200							
201							
202							
203							
204	**Total Retention Expenses**						
205	**(Infrastructure Budget Line 8)**						
206							
207	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of***						
208	***the CP's contract and how the costs were determined:***						
209							
210							
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221							
222							
223	**Community Partner <u>Infrastructure</u> Budget Report - Business Start Up Costs - Prep Budget Period**						
224							
225	**Row 9 - Office Equipment**						
226	Description of Expense	Cost					
227							
228							
229							
230							

	A	B	C	D	E	F	G
231							
232							
233	**Total Office Equipment**						
234	**(Infrastructure Budget Line 9)**						
235							
236	***Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were***						
237	***determined:***						
238							
239							
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251							
252	**Row 10 - Office Furniture**						
253	Description of Expense	Cost					
254							
255							
256							
257							
258							
259							
260	**Total Office Furniture**						
261	**(Infrastructure Budget Line 10)**						
262							
263	***Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:***						

Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period

Row 12 - Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate	22.0%	Total Fringe	$ -
			Total Program Staffing including Fringe (Infrastructure Budget Line 12)	**$** -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 13 - Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses (Infrastructure Budget Line 13)	

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	**12.00%**	**$ 25,145.00**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

MCCN will charge an indirect cost/administrative overhead rate of 12% on the total Infrastructure budget.

	A	B	C	D	E	F	G
359							
360							
361							
362							
363							
364							
365							

Community Partner Infrastructure Allocation Worksheet

	Massachusetts Care Coordination Network						
Infrastructure Investment Funding	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Infrastructure Funding**
TOTAL FUNDS AVAILABLE	$ 450,000	$ 918,750	$ 783,090	$ 1,308,787	$ 727,272	$ 301,028	$ 4,488,928
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
SHFS	$ 205,040	$ 168,578	$ 289,816	$ 272,976	$ 276,697	$ 279,136	$ 1,492,243
							$ -
							$ -
	$ -						$ -
	$ -						$ -
	$ -						$ -
Total Technology	$ 205,040	$ 168,578	$ 289,816	$ 272,976	$ 276,697	$ 279,136	$ 1,492,243
Workforce Development							$ -
SHFS	$ 2,750	$ 39,000	$ 39,000	$ 39,000	$ 39,000	$ 39,000	$ 197,750
Advocates	$ 875	$ 7,800	$ 7,800	$ 7,800	$ 7,800	$ 7,800	$ 39,875
BAMSI	$ 875	$ 7,800	$ 7,800	$ 7,800	$ 7,800	$ 7,800	$ 39,875
HMEA	$ -	$ 7,800	$ 7,800	$ 7,800	$ 7,800	$ 7,800	$ 39,000
BCIL	$ -	$ 7,800	$ 7,800	$ 7,800	$ 7,800	$ 7,800	$ 39,000
BayPath	$ -	$ 7,800	$ 7,800	$ 7,800	$ 7,800	$ 7,800	$ 39,000
Total Workforce Development	$ 4,500	$ 78,000	$ 78,000	$ 78,000	$ 78,000	$ 78,000	$ 394,500
Business Start Up Costs							$ -
SHFS	$ 206,166	$ 222,648	$ 227,107	$ 23,535	$ -	$ -	$ 679,456
Advocates	$ 4,575	$ 44,530	$ 45,421	$ 4,707	$ -	$ -	$ 99,233
BAMSI	$ 4,575	$ 44,530	$ 45,421	$ 4,707	$ -	$ -	$ 99,233
HMEA	$ -	$ 44,530	$ 45,421	$ 4,707	$ -	$ -	$ 94,658
BCIL	$ -	$ 44,530	$ 45,421	$ 4,707	$ -	$ -	$ 94,658
BayPath	$ -	$ 44,530	$ 45,421	$ 4,707	$ -	$ -	$ 94,658
Business Start Up Costs	$ 215,316	$ 445,298	$ 454,212	$ 47,070	$ -	$ -	$ 1,161,896
Operational Infrastructure							$ -
SHFS	$ -	$ 143,758	$ 124,300	$ 199,879	$ 203,600	$ 132,962	$ 804,499
Advocates	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BAMSI	$ -	$ -	$ -	$ -	$ -	$ -	$ -
HMEA	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BCIL	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BayPath	$ -	$ -	$ -	$ -	$ -	$ -	$ -
SHFS - Admin - 12%	$ 25,145	$ 52,840	$ 59,054	$ 66,103	$ 66,996	$ 58,812	$ 328,950
Operational Infrastructure	$ 25,145	$ 196,598	$ 183,354	$ 265,982	$ 270,596	$ 191,774	$ 1,133,449
TOTAL INVESTMENTS	$ 450,000	$ 888,474	$ 1,005,382	$ 664,028	$ 625,293	$ 548,910	$ 4,182,087

Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date
Technology	CareManagement Software	CareManagement Tool developed and tested	10/01/17	04/02/18
Technology	CareManagement Software	MCCN Staff Trained in CMT	04/02/18	05/31/18
Technology	MCCN Staff	IT Manager Hired	01/01/18	03/01/18
Technology				
Workforce Development	Recruitment	Key MCCN Staff Recruited and Hired	10/02/17	05/01/18
Workforce Development	Training	Training curriculum and plan for staff developed	11/15/17	01/31/18
Workforce Development				
Workforce Development				
Business Start Up Costs	MCCN Staff	Director of Integrated Care Management Hired	09/01/17	11/20/17
Business Start Up Costs		Intake/Outreach Coordinator Hired	09/01/17	05/01/18
Business Start Up Costs		Care Coordination Staff Hired for June 1 start date	11/01/17	05/01/18
Business Start Up Costs				
Operational Infrastructure	MCCN Staff	Director of Quality Management Hired	01/01/18	06/01/18
Operational Infrastructure				
Operational Infrastructure				
Operational Infrastructure				

MCCN

MASSACHUSETTS CARE COORDINATION NETWORK

Updated Participation Plan

October 6, 2017

7.5 Updated DSRIP Participation Plan

The Bidder's response to this **Section 7.5** shall constitute the Bidder's Initial DSRIP Participation Plan as described in **Section 4.1** of **Attachment A**.

A. Executive Summary (not to exceed 2 pages)

The Bidder shall describe its five (5) year business plan for implementing the LTSS CP program. This plan shall include, but is not limited to:

1. **The Bidder's goals, identified challenges related to the care delivery system and behavioral health, and proposed solutions to be effectuated through the LTSS CP program;**
2. **The number of Assigned and Engaged Enrollees the Bidder intends to support under the Contract;**
3. **The Service Areas for which the Bidder is bidding;**
4. **The Bidder's plans to operationalize the LTSS CP program and time frames associated with implementing such activities.**

Health outcomes of individuals with disabilities and behavioral health needs are poorer than those of the general population. For example, adults with cognitive disabilities have much higher rates of chronic conditions than those without disabilities, are five times more likely to have diabetes, three times more likely to have arthritis, and twice as likely to have asthma and heart-related conditions (Krahn and Fox, 2014). These poor health outcomes present a challenging picture for the ACOs/MCOs who are charged with not only meeting their health care needs in an integrated system, but doing so in a way that also reduces TCOC. Our goal at MCCN is to use our deep expertise and understanding of these populations and build a new system that integrates care, reduces those disparities and creates a solid Partner network throughout Massachusetts that is able to quickly respond to the health care needs of historically vulnerable populations. Using a life-course approach to health inequities (US DHHS HRSA/MCH, 2010), the Partners of MCCN will work with all of the community connections as outlined in the next section to address such social determinants of health as environmental living conditions; social and personal relationships and connections within the community; employment opportunities; ability to self-care; ability to meet transportation needs; and meaningful activities such as recreation, volunteering and educational opportunities.

The MCCN is proposing to support a total of 4500 individuals in three regions of the state: Northern, Central and Southern. The Partners are prepared to support 1500 Enrollees per region. All Partners have longstanding expertise and programming in all three regions, supporting children and adults in community settings and through behavioral health supports. Each Partner would not be a new entity to the regions, but are already known and trusted providers. Our involvement as the LTSS CP would strengthen the ties that currently exist. Our Partnership is unique in that the MCCN LTSS CP was built to align with the BH CPs (Advocates and BAMSI are bidding) in the Northern, Central and Southern regions on day one, ensuring true integration at the outset and a more efficient way to exchange clinical information among providers in the three regions. We have worked with the potential BH CPs as we have designed this LTSS CP to ensure the elimination of any duplication. In addition, it is the intention of the MCCN to bid on

the Enhanced CP RFR, to be released in the summer, given the clinical and behavioral health complexity the Partners experience in managing the needs of their populations today.

Our broad plan **(see 7.5.f)** to operationalize the MCCN is as follows:

- RFR submitted in May 2017. Partners continue to meet once a month to continue development of LTSS CP and fully develop Krokidas & Bluestein contract on roles and responsibilities and vet software vendors while waiting on potential award
- MassHealth will notify MCCN of success of bid in August 2017
- MCCN will select care coordination software, identify office space in existing buildings (6 locations) throughout the three regions, sign Partner contract in October 2017
- In November, Director of Integrated Care Management will begin
- Marketing and outreach materials designed and developed by November 2017
- Marketing and outreach to ACOs/MCOs will begin in January with expected contracts to be signed in February
- Caseload/ratio expectations to be finalized by May 2018
- November through February, care coordination software tool is configured and operational. Testing phase and training will begin in February.
- Full compliance with EOHHS readiness review to be completed in March 2018
- IT Manager begins March 1, 2018
- Intake/Outreach Coordinator, and LTSS Care Coordination staff begin on May 1, 2018 and begin their training programs.
- Director of Quality Management and Billing Specialist begins June 1.
- In June, the first 250 Enrollees begin (all three regions) plus 250 per quarter per region for remaining PBP. Thereafter, the MCCN expects to enroll 250 Enrollees per quarter, per region until the 1500 per region is reach by end of Year Two.

B. Supporting Populations and Community Engagement (not to exceed 2 pages)

1. For each Service Area(s) for which the Bidder is bidding, the Bidder shall describe its connections to the community and community members…

The following chart is a snapshot of the vast array of MCCN collaborations, partnerships, and connections by region.

Community Connections - Northern Region	
Coalitions & Advocacy Groups	Association of Developmental Disability Association (ADDP), Federation for Children with Special Needs, Provider's Council, Parents & Professional Advocacy League (PPAL); Creating Our Commonwealth; Mass Families Organizing for Change
Medical/Psychiatry	Community Health Centers; All Skilled Nursing Facilities & Rehabilitation Centers, Primary Care Group Practices; Psychiatric Facilities; Hospitals; Neuropsychology, Acupuncture, Mental Health and Substance Abuse Providers, Visiting Nurses Associations, Center for Developmental Disabilities Evaluation & Research (CDDER)
Community-Based Organizations	Homemaker/Person Care Agencies, Alzheimer's Association, Brain Injury Association of Massachusetts, Councils on Aging/Senior Centers, Assisted Living Facilities, SHINE (Serving Health Information Needs of Everyone), Faith-Based Organizations, Independent Living Centers, ASAPs, Easter Seals, Colleges & Universities; Employment and Workforce Development Programs; United Way; Best Buddies
Health & Wellness	Nutrition Counselors, PT, OT, YMCA, YWCA, Fitness & Yoga Centers, Walking Clubs, Recreational Services Programs, Family Support Centers, Special Olympics, Support Groups, Social Clubs and Programs
Social Service Providers	All Housing Authorities, SMOC, Food Pantries, Salvation Army, Department of Transitional Assistance, Catholic Social Services
Community Connections - Central Region	
Coalitions & Advocacy Groups	Association of Developmental Disability Association (ADDP), Federation for Children with Special Needs, Provider's Council, MetroWest Aging and Disability Consortium, MetroWest Prevention & Wellness Partnership Advisory Council, MetroWest Advocacy Coalition, Massachusetts Parent Training and Information Center; Creating Our Commonwealth; Advocates for Autism of Ma (AFAM), Mass Families Organizing for Change
Medical/Psychiatry	Community Health Centers; All Skilled Nursing Facilities & Rehabilitation Centers, Primary Care Group Practices; Psychiatric Facilities; Hospitals; Neuropsychology, Acupuncture, Mental Health and Substance Abuse Providers, Visiting Nurses Associations, Framingham Union/Leonard Morse/Marlborough Hospital, UMASS Memorial Medical Center, Saint Vincent , Hospital, Child and Adolescent NeuroDevelopment Initiative (**CANDI**), Center for Autism & NeuroDevelopmental Disorders (CANDO), EPIC Home Health Services; E.K. Shriver Center; Maxim Health Care, Community Health Ling, Long Term Pharmacy, Comfort Care, Gentiva, Fairlawn
Community-Based Organizations	Homemaker/Person Care Agencies, Alzheimer's Association, Brain Injury Association of Massachusetts, Councils on Aging/Senior Centers, Assisted Living Facilities, SHINE (Serving Health Information Needs of Everyone), Faith-Based Organizations, Independent Living Centers, ASAPs, Easter Seals, Colleges & Universities; Employment and Workforce Development Programs; United Way; Best Buddies;
Health & Wellness	Nutrition Counselors, PT, OT, YMCA, YWCA, Fitness Centers, Walking Clubs, Recreational Services Programs, Family Support Centers, Special Olympics, Support Groups, Social Clubs and Programs
Social Service Providers	All Housing Authorities, SMOC, Food Pantries, Salvation Army, Department of Transitional Assistance, Latino Health Insurance Program, Central Massachusetts Housing Alliance, Worcester Community Action Council's fuel

	assistance program; Catholic Social Services; Lutheran Community Services
Community Connections - Southern Region	
Coalitions & Advocacy Groups	Association of Developmental Disability Association (ADDP), Federation for Children with Special Needs, Provider's Council, Creating Our Commonwealth; Elder First Community Resources Diocesan, MA Families Organizing for Change, Mass Families Organizing for Change
Medical/Psychiatry	Community Health Centers; All Skilled Nursing Facilities & Rehabilitation Centers, Primary Care Group Practices; Psychiatric Facilities; Hospitals; Neuropsychology, Acupuncture, Mental Health and Substance Abuse Providers, Visiting Nurses Associations, Good Samaritan Hospital, Neighborhood Health Center; Health First Complex Care Team
Community-Based Organizations	Homemaker/Person Care Agencies, Alzheimer's Association, Brain Injury Association of Massachusetts, Councils on Aging/Senior Centers, Assisted Living Facilities, SHINE (Serving Health Information Needs of Everyone), Faith-Based Organizations, Independent Living Centers, ASAPs, Easter Seals, Colleges & Universities; Employment and Workforce Development Programs; United Way; Best Buddies ;Widening The Circle: Real Friends Project; "My Generation" Seniors
Health & Wellness	Nutrition Counselors, PT, OT, YMCA, YWCA, Fitness Centers, Walking Clubs, Recreational Services Programs, Family Support Centers, Special Olympics, Support Groups, Social Clubs and Programs
Social Service Providers	All Housing Authorities, SMOC, Food Pantries, Salvation Army, Department of Transitional Assistance, Catholic Social Services; WYSE Adult Day Health, Sullivan Care Solutions;

2. The Bidder shall describe how it will grow community connections in the Service Areas the Bidder intends to serve, in alignment with Section 3.7.

All Partners have long standing relationships in the three regions for which the MCCN is bidding. Within these regions, there are established linkages and affiliations will be leveraged to connect the MCCN with new community resources in a meaningful way. MCCN Partners all have relationships via our combined leadership on trade organizations and industry-wide Committees. Partners operate a total of 9 Family Support Centers (FSC) which serve as a natural information point and are well connected to Families Organizing for Change. Connections go well beyond human services and extend to entities such as corporate partners, vendors, and Chambers of Commerce. Each Partner's FSC has committed to outreach in each of the areas to develop a MCCN campaign to educate the local community resources as well as maintain a database of resources within each FSC. In addition, Partners such as BAMSI operate a Helpline which is an Information and Referral Resource for the Southern region and maintains a data base of services throughout the region. Local workshops, conferences and symposia in the three regions will be staffed with MCCN marketing staff through the Lead. MCCN also plans to bring staff together from the three regions at least quarterly for training and development and to share resource experiences. Often these networking opportunities uncover new ideas and strategies for collaboration and resource development. The website www.mccn.org will also be used to grow these local connections.

3. The Bidder shall describe its plans to ensure staff maintain up to date information on available service providers and community resources in the Service Areas covered by the Bidder.

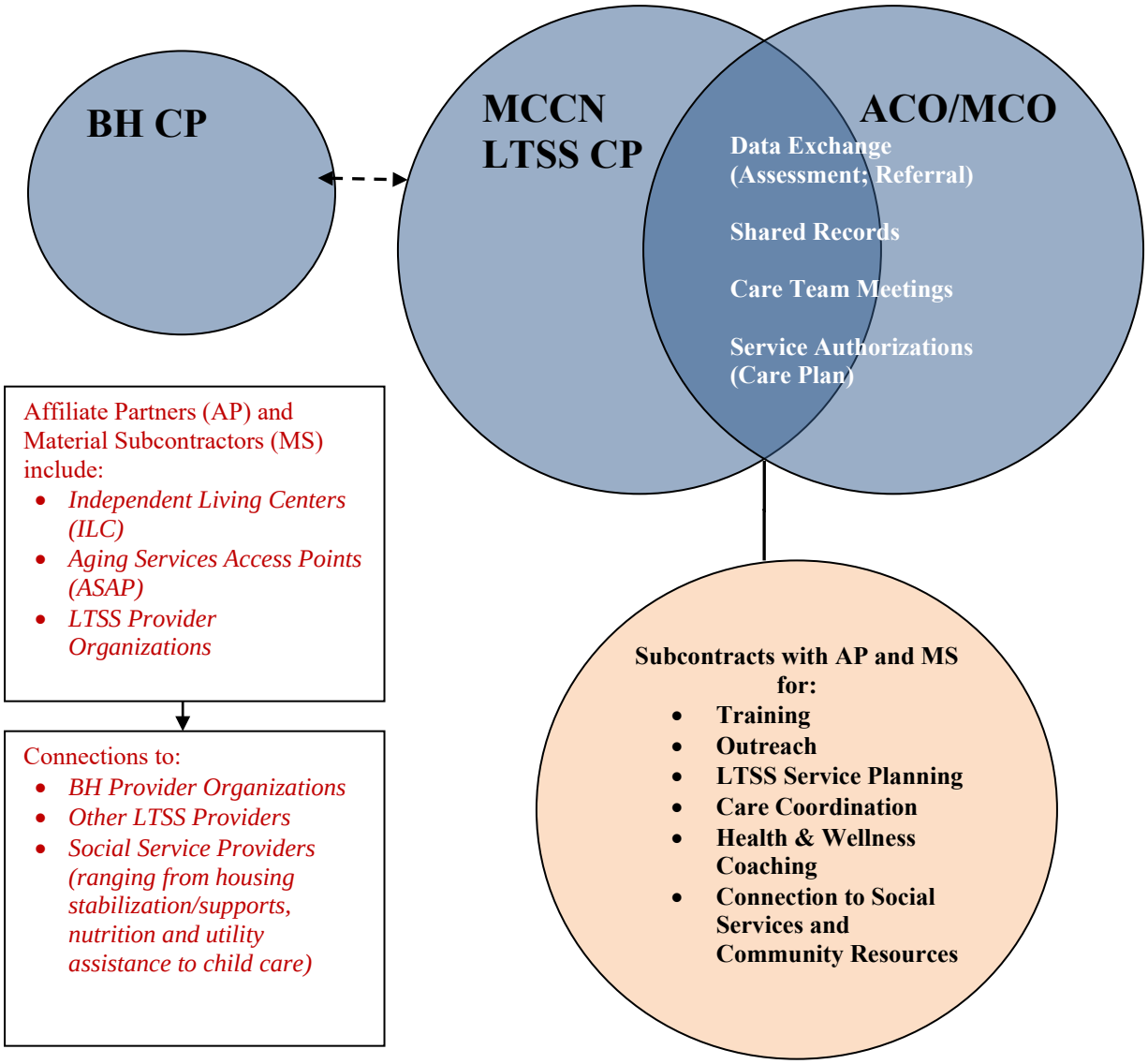
The MCCN has developed a collaborative training process in which training is provided in the three regions once a month and open to any staff at the MCCN member agencies. At each of

these training sessions, staff will be provided with updated community resource lists and MCCN listserves will be developed and updated in real time.

C. Community Partner Supports and Activities (not to exceed 10 pages)

For the following subsections, the Bidder shall describe how it will provide LTSS CP Supports, as described in Section 2.3.A of Attachment A.

MCCN will utilize a Shared Function Model as it works with EOHHS, ACOs and MCOs to provide integrated service delivery. The following diagram illustrates how the MCCN LTSS CP links to all stakeholders, including the BH CPs.



1. Outreach, including but not limited to:

a. Planned strategies to locate and engage with Assigned Enrollees with complex LTSS needs.

The MCCN Intake/Outreach Coordinator will receive information on the Assigned Enrollees from the ACO with a completed assessment. This referral will provide the Care Coordinator with the proper contact information the individual or for the individual's surrogate. If the referral provided does not have the necessary contact information, a number of steps will be taken to reach the Assigned Enrollee by their assigned LTSS Care Coordinator. There will be a minimum of three contact attempts made to reach the potential Enrollee.

First, the MCCN will contact other service providers, LTSS providers and/or MCEs. The LTSS Care Coordinator will encourage those entities to inform the Assigned Enrollee of the referral. The LTSS Care Coordinator may also stop by locations the Assigned Enrollee may frequent or go to their home or last known residence and, if appropriate, reach out to family. MCCN Partners who currently have care management contracts with MCEs and OneCare entities have employed these strategies and found them to be very effective in locating difficult to reach individuals.

The Care Coordinator will approach the Assigned Enrollee from a person-centered methodology and will become their primary contact. The approach requires the Care Coordinator to consider and evaluate a number of factors including language, method of contact or needed supports. The Care Coordinator will meet the Assigned Enrollee as a unique individual and understand their perceived needs, desires and goals. It is through this relationship that the MCCN will be able to engage the individual and develop a trusting and therapeutic approach that can then be leveraged throughout the continuum of care.

The Seven Hills 7-member marketing department will work with MCCN Partners to develop brochures and other materials for distribution to Assigned Enrollees and their support network. The materials will clearly define the role of the MCCN, the Care Coordinator, the benefits of engaging with the services, as well as the Assigned Enrollee's right to decline the service, ask for a different care coordinator or a different LTSS CP. The materials will be in the individual's primary language and will be written at the 8th grade level. These materials will be reviewed by the MCCN Care Coordinator and the individual during the outreach period and the Care Coordinator will be prepared to answer all questions.

The Care Coordinator will encourage participation while at the same time being clear that the person can choose to decline MCCN services. If the person initially declines, the MCCN Care Coordinator will ask if they can be in touch to check in on their decision again in a few weeks. The Care Coordinator will look for early opportunities to be helpful to the individual, exploring areas of challenge in their life and offering assistance as a way to engage the Assigned Enrollee. Offering to assist with individual needs can begin to foster a relationship and over time support the individual's eventual choice of engagement with the MCCN. Once the individual has elected to engage with the LTSS CP, the MCCN Care Coordinator will complete the Participation Form with the individual as well as any needed releases. Throughout the engagement process, the Care Coordinator will carefully explain the value and purpose of shared communication across various supports, including the individual's PCP. If the individual is reluctant to sign documents and consent to the service or information sharing, the Care Coordinator will leave the documents with the individual and follow up with them or encourage the individual to contact them with any questions or concerns that may come up at any time. Once the Participation Form is complete

and placed in the Enrollee's record, the MCCN Care Coordinator will begin the care planning process within five (5) business days and will inform the ACO/MCO of the status of the referral.

2. LTSS care planning, including but not limited to:

a. How the Bidder will ensure the Enrollee has meaningful participation in the development and management of the LTSS Care Plan; and

b. A description of the Bidder's protocols for providing informed choice of LTSS programs and providers as part of LTSS care planning.

The overarching goal of the MCCN is to ensure Enrollees and their family members take an active and shared role in their care. In the Deloitte Center for Health Solutions 2015 Survey of US Health Care Consumers, consumers were clear about seeking engagement and that partnering with providers continued to be important. Our goal is to engage each Enrollee in their care by providing them with the tools necessary to become informed and in charge of their care. Part of this engagement process is to inform both the Enrollee and their family about their health care needs and the healthcare system they will be participating in. Before the first PCP visit, each Enrollee will be educated on the process so they can have the confidence and skills to navigate this new environment. The ability to be truly engaged will be measured in Enrollee satisfaction scores around engaging in their own care, partnership with their healthcare organizations, and having a voice in the development of organizational practices. Using the roadmap as outlined at www.patientfamilyengagement.org as a guide, curricula will be developed for both children and adults which will build from the Partners' current care coordination tools and will include:

Care Coordination Tools
• A library of simple, condition-specific reference sheets and videos Enrollees can access • Mobile apps as a function of the care coordination software or fitness/health monitoring • Medical conditions translated into simple, easy to understand language • Ensure family and caregivers understand medical direction by using teach-back methods • Invite all Enrollees and families to ask questions about their plan • Utilize peer educator support programs either online or in person • Provide information to Enrollees on existing advocacy networks • Discuss with Enrollees barriers to meeting their treatment goals • Utilize a harm reduction approach when making behavior changes • Include outlining expectations for Enrollees and communicating expectations to medical providers • Provide opportunities to participate in research projects and conferences • Inform Enrollees of state and national stakeholder meetings • Develop staff training that incorporates the process Enrollees and their families use to participate in their medical care • Ensure this is a topic of the LCAB and CAB • Include Enrollee and family engagement/satisfaction in staff performance reviews

The care plan will be completed with the level of participation identified by the Enrollee or other supports the individual chooses within 90 days of assignment to the MCCN. The Care Coordinator will work with the individual to identify the best approach to maximize participation in their plan based on their desires and needs.

Care plan development and revision commences at the time of enrollment or when the Enrollee has life events resulting in the need for a review of the plan, but minimally, at least every 12 months. A care plan review may be needed as a result of a change in functional status due to an acute event such as a hospitalization or an illness. In addition, changes in an Enrollee's need for services and supports may occur naturally that require a different mix of services such as fewer

or increased LTSS services or different providers of the services. Technology can be used effectively to monitor health and has been shown to be particularly effective with individuals with chronic health issues and promotes positive health behavior change (Deloitte, 2015). The care plan developed by the ACO/MCO, any previous LTSS care plans, and any social service or flexible supports will be reviewed with the Enrollee and the MCCN Care Coordinator. The Care Coordinator will use a variety of approaches to ensure the Enrollee understands the assessments being reviewed, including translation services, breaking the assessment down into smaller parts, utilizing an American Sign Language interpreter, seeking assistance from natural supports, or using assistive technology and other technologies.

The MCCN Care Coordinator will seek input from other members of the Enrollee's support network, including AFC providers, day habilitation directors, DDS service coordinators and others. A list of these supports, service levels and any identified natural supports will be documented in the care plan with contact information. The care plan will meet all the expectations identified in the RFR attachment, Model A, Section 2.3. The care plan will incorporate the results of the comprehensive assessment and social/flexible support assessment. The MCCN Care Coordinator will review these options, discussing pros and cons including which services the person may not be eligible to receive. The Care Coordinator will be very clear that these services require their own authorization process and the person may or may not be found eligible for each service. If ineligibility occurs, the Care Coordinator will discuss alternative solutions. The care plan will include a list of all social service supports and the contact information identified to meet the Enrollee's social determinants of health. Ongoing communication with key members of the person's support network will be written into the care plan. The care plan will be shared and approved by the Enrollee's PCP; developing relationships with the PCPs will be critical to ensure integration and participation between the MCCN services and the PCP. The care plan will document the contact information for the PCP, the MCCN Care Coordinator and the ACO/MCO care coordinator and will include any LTSS service authorizations.

3. Care team participation, including but not limited to:

a. How the Bidder will promote integration of LTSS communication across all stakeholders, and exchange essential documentation as part of the Bidder's participation on Engaged Enrollees' care teams; and

b. How the Bidder will provide LTSS expertise and advocate for appropriate LTSS and care as part of the Bidder's participation on Engaged Enrollees' care team.

The MCCN will promote the integration of LTSS communication across all stakeholders, and exchange essential documentation through a variety of structures and mechanisms. First, the MCCN Care Coordinator will work with the Enrollee and the ACO/MCO to identify key providers and stakeholders. These could include family, friends, LTSS providers, primary care, state agency service coordinators/case managers, and behavioral health providers. Once identified, the Care Coordinator will contact these individuals within three business days. The LTSS Care Coordinator will provide education to the Enrollee on the value of integration for overall health and wellbeing and encourage the Enrollee to allow for full communication within their network. The Care Coordinator will gather contact information for identified providers and other stakeholders and, with proper releases, reach out to these individuals. An important step for the Care Coordinator will be educating this team of people about the MCCN CP role, LTSS options and the value of integrated communication for the Enrollee. During contact with these

potential care team members, the LTSS Care Coordinator will ask each individual how best to communicate with them. This could range from document sharing via care management software, utilizing the Mass HIway, faxing to medical and behavioral health providers, phone contacts, email, and formal and informal meetings.

The MCCN Care Coordinator will participate in all care planning meetings and will provide input to the ACO/MCO Care Manager. They will link LTSS service provision, individual updates and changes to the care team via documentation sharing as identified above, participation in formal and informal meetings and through regular email or telephone communication. The MCCN will use its extensive expertise regarding the various populations to provide education, ideas and resource suggestions to the care team and to other critical stakeholders. The MCCN will have access to a number of experts at their organizations that could assist the entire care team with a variety of concerns and challenges as well as providing subject matter expertise and education. With commitment to a person-centered approach along with extensive expertise, the MCCN will be well positioned to advocate with and for the Enrollee, helping the care team provide the best possible care and meeting each Enrollee's identified LTSS needs.

4. LTSS Care Coordination, including but not limited to:

a. How the Bidder will monitor and manage status/life cycle events that may change the Enrollee's LTSS needs; and

b. How the Bidder will support and encourage Enrollees' ongoing engagement in their care planning and implementation of their care plan. Include strategies related to motivational interviewing and promoting self-determination.

Over the course of an Enrollee's engagement with the MCCN, there will be status and life cycle events that necessitate a change in the individual's needs and related services and supports. The MCCN Care Coordinator will review the utilization of LTSS service provision monthly and evaluate it for any variances in care patterns. The MCCN may find out about such changes through LTSS or other service providers, the Enrollee, their informal support systems and/or their surrogate. As part of the care coordination process, the MCCN Care Coordinator will reinforce with providers and involved entities/individuals the need for timely and open communication about the dynamic and changing needs of the Enrollee. Upon notification of a status or life cycle event, the MCCN Care Coordinator will contact the Enrollee within 48 hours to discuss the situation with them, and with relevant providers and care team members, and assess the need for a modification in service levels and the care plan.

The Enrollee's engagement is critical to the initial development and revisions to the care plan that will be supportive of their care, life goals and desires. The care team will use predictive analytics, provided by the MCEs, to determine who is at risk for increased health concerns or to monitor the high utilizers of health care supports. Families and other caregivers must always feel welcomed and encouraged to participate in the care process. Family involvement policies will be developed and shared with families at the launch of the MCCN and communicated to all staff who will see caregivers not as a distraction, but as a resource. Guided conversations with the Enrollee's caregiver following the MAPCP Toolkit (2013) will include:

- Do you have any questions about the care conversations we have had?
- What are your concerns about your health?
- How would you like us to communicate with your PCP?

- Who helps you with your care?
- What medical tasks are you asked to do? Are you comfortable with that?
- How are things going for you?
- What is working well? Not working well?
- Are you taking time for yourself? Are you aware of resources that can help you?

All MCCN Care Coordinators will be trained in Motivational Interviewing (MI) to encourage the Enrollee to articulate their personal goals and desires which are critical for self-determination. All of the Partners have trained MI interviewers who will provide the core training for staff. Through the application of MI techniques, the MCCN Care Coordinator will support the Enrollee in a process of asking, listening and informing to incorporate lifestyle modifications and behaviors to prevent disease complications, alleviate symptoms, and prolong and improve quality of life. Barriers can easily lead to non-compliance with care and create further complications including poor health outcomes. When these barriers are addressed upfront in the development of care plans and service delivery schedules, the provision of services is much smoother and the Enrollee's self-determination and locus of control is supported and reinforced.

LTSS Care Coordination Example: (Social Determinants of Health)

As an illustration of the effectiveness of LTSS Care Coordination, BAMSI participated in an ACO pilot project with Good Samaritan Medical Center in Brockton, part of the Steward Health Care Network. The Community Health Worker at Good Samaritan referred a 41-year-old female recently diagnosed with COPD and asthma, who had been admitted to the hospital five times in 2016. The patient had survived a house fire that left her homeless and as a result she was living in her car. She subsequently lost her car in an accident and was living in a nearby park. While she had applied for housing, she was at the bottom of the waitlist. She had no family, no transportation, and was without insurance. Without resources for medications, her COPD and asthma were not managed causing her to go to the ED repeatedly and be hospitalized. The patient was referred to BAMSI for help with her social needs. Advocacy with the local housing authority resulted in her being moved to the top of the waiting lists for housing. She was supported to complete applications for SSDI and transportation through a PT-1, both of which were rapidly approved. After she secured housing, furnishings were obtained through collaboration with a local organization. A PCP schedule and medication regimen were established and monitored by a BAMSI service coordinator. She has begun to build a support network within housing, has been linked with local food pantries and attends the BAMSI Clubhouse, which is helping her develop employment skills. With regular check-ins, she has remained without an ED visit or hospitalization for the past 6 months.

5. Support for transitions of care, including but not limited to:

a. A description of the Bidder's plan for providing informed choices in regard to LTSS programs and providers to Enrollees as part of transitions and how the Bidder will ensure supports are in place to enable successful transitions of care.

b. A description of steps the Bidder will take to ensure the Enrollee's stability and satisfaction post-transition.

Transitions from hospitals, nursing homes or other long term placements to home, primary and specialty care and or stakeholder systems are a critical time for Enrollees. An inadequate transition can result in repeat hospitalizations, decreased personal function and a worsening of chronic conditions (Jencks, Williams, Coleman, 2009). Done well, they enable the individual to

flourish in the community. The MCCN will be notified in real time by the ACO/MCO of an admission or a scheduled admission using the care coordination software that will link to the members of the Enrollee's care team. The MCCN will utilize the evidence-based, standardized transition tool of the Coleman Transitions Program®. This model will ensure an appropriate and complete transition from one care setting to the other. The transition process will be as follows:

Transition Process	
1.	MCCN Care Coordinator receives notice of the event from MassHealth
2.	Care Coordinator contacts ACO/MCO care manager and other providers to obtain information
3.	Care Coordinator will convey unique characteristics of the individual to ACO/MCO/PCP
4.	Care Coordinator assigned to the Enrollee will visit them while in the care setting to determine needs and/or changes in needs
5.	Following stay, Care Coordinator will attend discharge planning meeting and will adjust care plan and share with care team, Enrollee and caregivers
6.	Care Coordinator will work with family caregivers to ensure they understand the regimen for care, medications and other tools
7.	Care Coordinator will use role play to teach care skills to caregivers and/or the Enrollee
8.	Care Coordinator will review red flags with caregivers that may indicate worsening condition
9.	Care Coordinator visits the home within 48 hours post-discharge to review plan and assess for compliance
10.	Care Coordinator makes weekly follow-up phone calls during the first 30 days to review the Enrollee's progress, answer questions and document progress toward health care goals
11.	One week after discharge, a Care Coordinator separate from the one working with the Enrollee, calls to administer a three-question survey which asks whether hospital staff took preferences into consideration in deciding post-discharge care; whether the Enrollee had a good understanding of the things he/she was responsible for; and if the Enrollee had a solid understanding of the medication regimen. Results of the surveys will be reported back to the entire care team including the ACO/MCO/PCP.

The MCCN will select care coordination software that includes a patient portal in which Enrollees can access information and connect to clinical staff when needed. Enrollees can also give caregivers access to the portal, allowing them to fully participate in their loved one's care. The intent is that the Enrollees, their families and their providers have a single, comprehensive view of information regarding the Enrollee's health and life goals, preferences, diagnoses, medications, treatment options and choices. Each Enrollee will have one CP contact, their MCCN Care Coordinator, when leaving a care setting in the event of questions or concerns. The Care Coordinator will also ensure appropriate supports are in place to enable transition including such items as durable medical equipment and personal care attendants or other necessary services and supports. Within three days of discharge from facility-based care, the MCCN Care Coordinator will update the individual's care plan, electronic health record and provide-follow-up and transitional support to coordinate any LTSS and social services needed by the individual. The more actively involved the MCCN and other service providers are in the process that precipitates a transition of care, the more effective the MCCN will be in working with the MCEs to reduce unnecessary costs, and improve the health and wellbeing of the Enrollee.

All Affiliated Partners and Material Subcontractors have extensive experience providing transitions in care. The ASAPs in the Central Region just completed a five-year CMS grant for a Care Transitions Program and are currently among the top performers in the nation. ASAPs are trained in the Coleman Model® and have trained Coleman coaches and continue to offer the Care Transitions program with a contract through Blue Cross/Blue Shield.

The following example demonstrates MCCN's knowledge of requirements around transitions of care involving complex cases:

A young man with significant health issues including Cerebral Palsy, dysphagia, muscle contractures and seizures spent considerable time in long term hospital stays, acute care and rehabilitation facilities due to improper care in his biological home. After his last stay, it was determined that he not return to his birth home and left the hospital with a new permanent tracheostomy and g-j tube requiring much more complex care. A nursing home was the next option for this young man in his 20's.

Seven Hills was approached by the hospital and asked to find an AFC placement. The AFC Care Coordinator worked on a transition plan to assist him in applying for benefits, acquiring a rep payee, and connecting him to new community PCPs who were comfortable handling a complex-care patient. The AFC care team identified a couple who were a good match and were willing to try to support him in their home. Together, the team worked through additional supports that would be needed to be successful and keep him medically safe in a community-based setting. Additionally, the care team secured a small amount of funding to allow two weeks of respite for the caregivers. He has since become part of the family and has been with the couple for 7 years.

6. Health and wellness coaching, including but not limited to:

a. A description of the health and wellness education, coaching and health promotion programs or activities that the Bidder will offer to Engaged Enrollees, including the use of programs that are evidence-based.

MCCN will provide health and wellness coaching as directed by the Enrollee's care team and as indicated in the Enrollee's care plan. MCCN is proposing a three-tiered approach to health and wellness coaching:

1. Health Literacy Education: The U. S. Department of Health and Human Services (2010) has identified improved health literacy as being the single most important element to improving a person's health and wellness. Health literacy is the degree to which individuals understand their basic health information and services in order to make appropriate health decisions. The majority of Enrollees supported through MCCN will likely have significant cognitive/learning, neurological, emotional and/or cultural factors which interfere with their ability to gain sufficient understanding of their basic health information within a traditional healthcare delivery experience. MCCN's Care Coordinators will utilize culturally sensitive, developmentally appropriate and neuropsychologically-informed communication and education to Enrollees on how to reduce high risk behaviors and health risk factors such as smoking, inadequate nutrition and infrequent exercise, in order to improve their health literacy.
2. Direct Information Sharing: Care Coordinators will have linguistically and developmentally appropriate written materials and referral resources available to share with Enrollees on a number of important health-related topics and activities such as:
    - Health promotion activities such as smoking cessation and weight loss classes
    - Chronic disease management including diabetes management programs
    - The importance of annual physical examinations and routine preventive testing
    - Key vaccinations

- Stress reduction and mental health awareness (including topics such as signs and symptoms of substance abuse, depression, and anxiety and coping with loss and isolation)
- Being "Heart Healthy" and the importance of "knowing your numbers" (weight/BMI, blood pressure, cholesterol levels)
- Diet, exercise and sleep habits for a healthier life
- Treatment compliance
- Parenting/caregiver supports

3. Goal Setting and Team Engagement: Care Coordinators will assist Enrollees in setting health and wellness goals as part of their care planning and will ensure goals are documented in the MCCN care plan so that the team is engaged in supporting the Enrollee towards achieving the goals.

7. Connecting Enrollees to social services and community resources, including but not limited to:

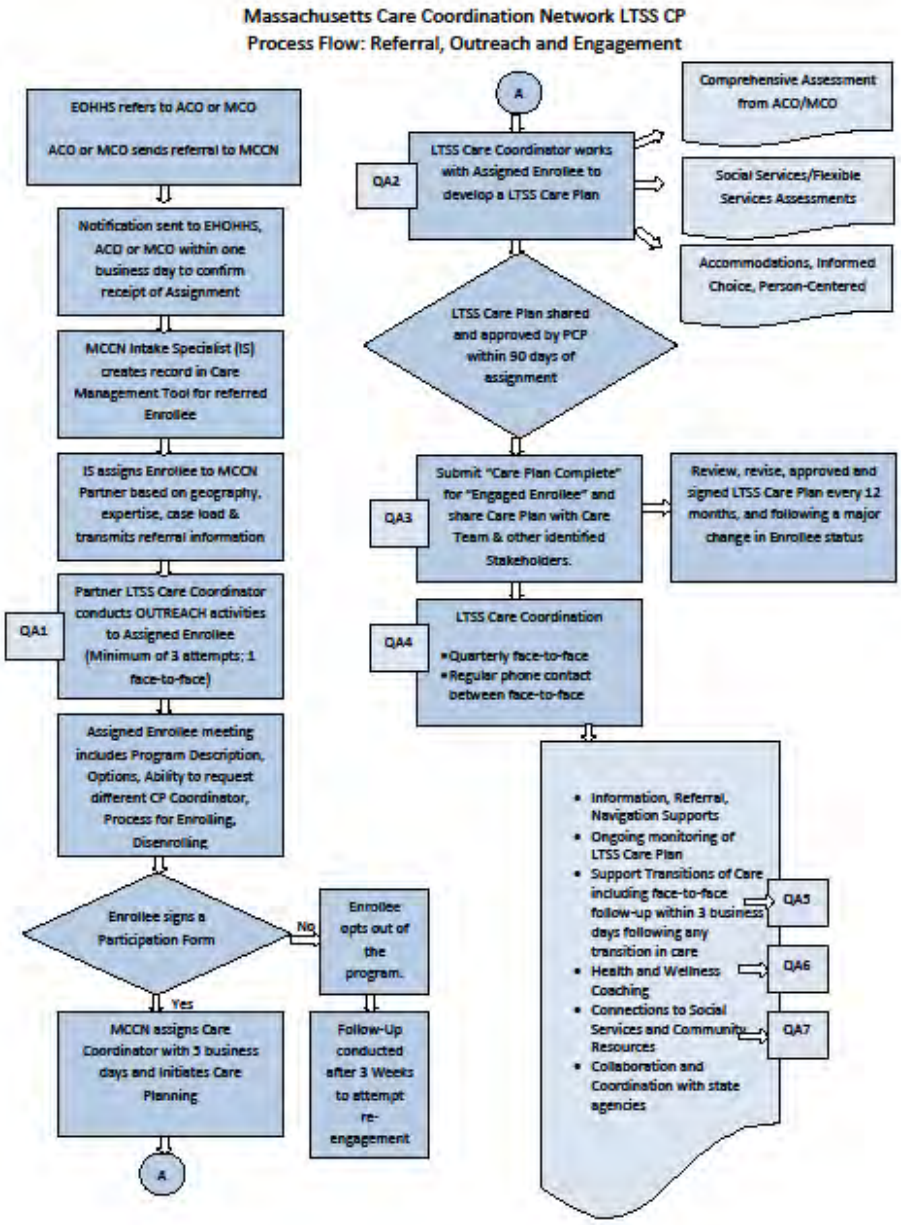
a. How the Bidder will evaluate social services needs for all Engaged Enrollees and facilitate access to Flexible Services for LTSS CP Engaged Enrollees who are enrolled in an ACO. Include proposed screening tool the Bidder intends to use; and b. How Bidder intends to ensure ongoing connections

b. How the Bidder intends to ensure ongoing connections to community resources and social services.

Recent studies have confirmed what we already knew: more than 80% of health outcomes are weighted more heavily on behavioral, emotional, financial and educational levels than on clinical issues (Robert Wood Johnson, 2014). The MCCN will work through its extensive relationships with SDOH providers to help meet the unmet needs of Enrollees. The first step in this need identification process is the Enrollee assessment. The assessment includes a thorough review of the person's current needs beginning with obtaining detailed information on the person's current supports and services, their medical/clinical diagnosis and reported presentations/behaviors, family dynamics and household composition, educational services, equipment needs, social/recreational needs, housing, legal assistance, transportation and training needs as well as identifying the Enrollee's/family's strengths and challenging issues. Much of this will come from the Enrollee's care plan.

The next step in this assessment process is the use of the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE). This tool was developed by the National Association of Community Health Centers (2016) and contains 21 domains ranging from personal characteristics to questions about family and home; money and resources; social and emotional health; and optional questions related to incarceration, refugee status, and feelings of safety. Based on the information gathered from this brief survey, a support plan is developed that outlines the goals and objectives for the Enrollee seeking access to flexible services, taking into consideration the person's and families' concerns. Care coordination supports can include providing coordination and information and referral to other state systems for support including supplemental help from other health and human service agencies, connections to local resources and information on local specialists and related healthcare providers. Family navigators through the nine Family Support Centers which operate in the three regions will also be critical linkages to the needed supports. Staff will facilitate community access and inclusion to other state and local services, housing, nutrition, other sources of funding, and local resources for support. The PRAPARE is administered upon intake, but is also part of the annual plan review to ensure that

the Enrollee's status in any of these domains has not changed. The following graph illustrates the anticipated process flow from initial referral through comprehensive care coordination, including all qualifying activities outlined in the Model Contract.



D. Innovative technologies for service delivery (not to exceed 1 page)

The Bidder shall describe innovative technological tools it currently has and specifically how it will use these tools for the delivery of LTSS CP Supports. Specifically, the Bidder shall describe its planned uses of technological tools, such as care management or coordination software, telehealth tools, tablets, smartphones and other adaptive technologies.

MCCN Partners use technology and Assistive Technology (AT) in a number of programs and have seen firsthand how it can transform an individual's life in the community. The most critical piece of technology to enable all members of the care team to communicate in real time is the care coordination software. As mentioned earlier, the Partners have vetted software companies and have two finalists; Netsmart and eHana. The care management software solutions that we are considering aggregate clinical data to provide us with a broad picture at the population level, will facilitate care coordination across providers, will track clinical quality measures and outcomes, and will allow us to manage claims across care providers. In addition, the software enables the Enrollee and their caregivers access to their health data at any time.

Because the care coordination roles are mobile, the MCCN Care Coordinators will be provided with smartphones and tablets to efficiently deliver services out in the community. Smartphones and tablets will provide access to the care management software for staff working in the field and will optimize effective communication, planning, and implementation of service delivery as well as eliminate duplication of data entering and storage, thus creating efficiencies.

Recognizing the transformational impact that AT plays in working with people who have complex LTSS needs, the MCCN is committed to developing a culture within its CP that embraces its use. Seven Hills Foundation employs a full-time AT Program Director and part-time AT Specialist who will consult to the CP. With over 25 years of combined experience working in the field of AT, these staff have been instrumental in putting systems and trainings in place to fully integrate the ongoing use and support of AT throughout Seven Hills. These efforts have resulted in improved learning, communication and socialization, and functional independence for many of the people supported. AT is often integrated and incorporated into personal health care plans and goals, and staff work closely with the local clinical teams to identify the AT needs of individuals. AT assessment and outcomes tools have been developed to help non-clinical staff work with individuals to identify their AT needs. Exciting collaborations with community partners and educational institutions such as Apple, Worcester Polytechnic Institute, UMass Lowell, and Massachusetts Academy of Math and Science, have brought in engineering solutions to introduce other low-tech assistive technologies solutions to staff and residents. These partnerships have also led to creating customized engineered solutions including SMART homes for individuals living in SHF residential homes. HMEA also has extensive experience and operates TechACCESS of Rhode Island, a non-profit resource center which offers people with disabilities access to AT services. MCCN envisions that existing AT staff trainings, assessment tools, and other resources currently being utilized by Partners will be made available to the MCCN Care Coordinators and staff to incorporate into service delivery. The following illustrates the positive outcomes for individuals with complex LTSS needs when AT is integrated to enhance service delivery: *" iPads are used for House Meetings. One has Proloquo2Go programmed for House Meetings, so that Rachel, who is nonverbal, can fully participate in the meeting topics, including menu planning and activity planning. It has been obvious that this is empowering for her and her housemates now wait to hear what she has to say."*

E. Personnel and Staffing (not to exceed 5 pages, excluding attachments)

The Bidder shall provide its proposed staffing plan to perform the Contractor Responsibilities set forth in **Attachment A**, including fully implementing the required scope of CP Supports as well as administrative aspects of the Contract. The Bidder shall provide:

1. An organizational chart attachment that identifies personnel, senior managers, and other staff by title to be assigned to accomplish the Contractor Responsibilities described in Attachment A;

See attached organizational chart for the MCCN service model.

2. A sample staffing model for the number of Engaged Enrollees in each Service Area as indicated by the Bidder in Attachment D, including the number of full-time equivalent (FTEs) for supervision, administration, and care coordination positions;

MCCN Staffing Model: Fully Enrolled with 4500 Enrollees

Vice President of Seven Hills Family Services (.10 FTE)
Director of Integrated Care Management (1 FTE)
Director of Quality Management (1 FTE)
Intake/Outreach Coordinator – RN (1FTE)
IT Manager (1 FTE)
Director of Quality Management (1 FTE)
Billing Staff (1.25 FTE)

3 Regions - Engaged Enrollees:	4500 Enrollees	
Care Coordinator Supervisor:	7	FTE
Care Coordinator:	41	FTE
Associate Care Coordinator:	7	FTE

3. A description of the Bidder's recruitment plans, including timelines to recruit staff for any personnel positions not currently filled, and job descriptions and qualifications for each personnel position (job descriptions shall be submitted as attachments). The job descriptions shall contain information regarding education, background, qualifications, credentials, and relevant recent work experience;

MCCN will utilize the following timeline for the recruitment of staff for any positions not currently filled. Job Descriptions for each of the following MCCN positions to be filled include:

- Director of Integrated Care Management
- Director of Quality Management
- Intake/Outreach Coordinator -RN
- IT Manager
- Billing Specialist
- Care Coordinator Supervisor
- Care Coordinator
- Associate Care Coordinator

Preparation Budget Period (November 1, 2017 - May 31 31, 2018) Note this section/timeline has been updated:

October 2017

- Begin staff recruitment plan utilizing various types of media and HR resources.

- Hire the Director of Integrated Care Management for November 20th start date.

November 2017
- Director of Integrated Care Management begins work on the project.
- Develop a staff training plan that delineates dates, locations and instructors.

January 2018
- Staff training curriculum is developed and completed for all required areas.
- Begin recruiting MCCN IT Manager and Intake/Outreach Coordinator utilizing internal and external job postings, hosting career fairs, etc.

February 2018
- MCCN LTSS Care Coordination Staff, Director of QM, and Billing Specialist recruitment begins

March 2018
- IT Manager begins March 1, 2018
- Main CAB meets

April 2018
- Develop and organize committees

May 2018
- Intake/Outreach Coordinator, 1 Care Coordinator Supervisor,3 Care Coordinators, and 1Associate Care Coordinators begin working May 1, 2018.
- All staff receive training in areas required by the contract, attend each respective provider's standard orientation training, and are trained to use the care management tool. Training is completed by May 31, 2018.

Budget Period One (June 1, 2018 - December 31, 2018)
- Director of QM and Billing Specialist begins June 1, 2018
- Additional 19 Care Coordination staff hired to care coordinate new enrollees as they become engaged

Budget Period Two (January 1, 2019 - December 31, 2019)
January-March 2019
- Additional 32 employees hired and trained to support more engaged Enrollees as census builds to 4,500 people.
- Staff complete annual fresher training corresponding to their hire date.

April-June, 2019
- Staff complete annual refresher training corresponding to their hire date.

July-September, 2019
- Staff completes annual refresher training corresponding to their hire date.

October-December, 2019

- Staff completes annual refresher training corresponding to their hire date.

Budget Period Three (January 1, 2020 - December 31, 2020)

January-March 2020

- Staff complete annual fresher training corresponding to their hire date.

April-June, 2020

- Staff complete annual refresher training corresponding to their hire date.

July-September, 2020

- Staff complete annual refresher training corresponding to their hire date.

October-December, 2020

- Staff complete annual refresher training corresponding to their hire date.

Budget Period Four (January 1, 2021 - December 31, 2021)

January-March 2021

- Staff complete annual fresher training corresponding to their hire date.

April-June, 2021

- Staff complete annual refresher training corresponding to their hire date.

July-September, 2021

- Staff complete annual refresher training corresponding to their hire date.

October-December, 2021

- Additional staff recruited and trained to accommodate staff turnover.
- Staff complete annual refresher training corresponding to their hire date.

Budget Period Five (January 1, 2022 - December 31, 2022)

January-March 2022

- Staff complete annual fresher training corresponding to their hire date.

April-June, 2022

- Staff complete annual refresher training corresponding to their hire date.

July-September, 2022

- Staff complete annual refresher training corresponding to their hire date.

October-December, 2022

- Staff complete annual refresher training corresponding to their hire date.

4. A description of how the Bidder will recruit and hire staff from the cultural and linguistic communities they intend to serve;

MCCN is aware of the tendency toward loss of personal identity that results from being an individual in the "service system". A pervasive loss of individuality, that sense of self, is too often the direct result. How we express our ethnicity and culture defines us individually. MCCN will always seek to understand each Enrollee's preferences and provide opportunities for full expression. We honor the personal histories of those we support and will build individual service plans to meet those wishes.

As part of the MCCN staff recruitment process, every effort will be made to provide staff who can accommodate the linguistic and/or cultural needs of the Enrollees. All staff that will work with an individual will be required to be proficient in the individual's preferred communication

style; whether it is another language, ASL or use of an augmentative communication device, and training will be provided to accommodate this requirement. Seven Hills and all MCCN partners currently have staff that is representative of the cultural and linguistic needs of each regional population they serve. Linguistic and culturally competent services to current populations include: Cape Verdean; Cambodian; Native American; Lithuanian; Portuguese; Creole; Haitian; Puerto Rican (and other Spanish speaking communities); Vietnamese; and multiple countries from the African diaspora including Ghana, Sierra Leone, Liberia, Gambia and Nigeria.

MCCN will contract when necessary with translation services to support individuals and families with other language needs. The Partners have worked closely over the past several years with The Language Bank at Ascentria Community Services Inc. and other such providers to offer interpreter and translation services to clients, and will utilize this service to provide translation for staff and Enrollees.

Our cultural competency will not begin and end with the recruitment of bilingual staff. MCCN has an agency-wide commitment toward understanding the language, beliefs, communication styles, actions, social groups and values of the racial and ethnic backgrounds of the Enrollees and families it will support. For example, in the Cambodian community, health-related information, particularly around gynecological issues, is best delivered with a female elder in the room. In addition, all program materials will be provided in English, Spanish, and other languages, as needed. The MCCN protocol will be to translate critical documents in the language that is native to the Enrollee.

All staff providing MCCN services will receive cultural competency training. Staffs' skill on providing cultural competence will be assessed through direct observation and feedback from observation of Enrollee interactions. Staff members will be given self-assessments on their understanding and attitudes toward culture and belief systems. Training will be conducted annually to reinforce these skills.

5. A description of how the Bidder will ensure that all staff meet the competencies and trainings requirements in Section 2.2.B of Attachment A by Operational Start date; and

One of the benefits of a partnership such as the MCCN is the ability to draw from the deep training expertise in dozens of topic areas for use within the CP. Because of the multi-regional nature of the CP, the MCCN proposes local training, once a month, that will be open to all of the Partners and their staff. During the first 6 months of the Budget Preparatory Period, each Partner will be presenting their trainings and the Partnership, collectively, will select those that will be standardized across all regions. The MCCN will ensure that all staff who work directly with Assigned or Engaged Enrollees complete orientation trainings and annual refresher trainings on topics including, but not limited to: Cultural Competency; Accessibility and Accommodations; Independent Living and Recovery Principles; Motivational Interviewing; Conflicts of Interests, including but not limited to those described in Section 2.4.D. of the Model Contract, and the MCCN's mitigation strategy for conflict of interest; Health and Wellness Principles; and for Care Coordinators and supervisory staff, Person-Centered Planning Processes (using curricula approved by EOHHS); and lastly, MassHealth State Plan LTSS and Eligibility Criteria. This ensures fidelity to the training models and continuity across the partnership.

The Seven Hills Corporate College provides in-person and online training to hundreds of staff and community groups annually and serves as a focal point for its training locations throughout the Commonwealth. These sites, located in Worcester; Middleton; Sturbridge; Fall River; New Bedford; Oak Bluffs; and Woonsocket, Rhode Island provide the amenities necessary to accommodate training groups and have video conferencing capability and kitchen facilities. All of these training sites will be made available to the MCCN Partners.

Advocates has training locations available in Framingham, Waltham and Woburn and can offer a number of specialized trainings to the MCCN including Motivational Interviewing; Trauma Informed Care; SBIRT (screening brief intervention and referral to treatment for substance use disorders); positive psychology; smoking cessation; diabetes management; and health observations. In addition, through a care management contract with Celticare, Advocates has access to a variety of clinical trainings that include CEUs at no cost. BAMSI has training sites in Brockton, Middleboro, Plymouth, Foxboro and Worcester as well as a library of more than 200 specialized clinical and medical trainings.

6. A description of the Bidder's staff retention strategy.

Each Partner offers its staff various incentive programs as part of its retention strategy. Our goal is to show that the deep expertise of the MCCN Partners-combined with solid staff, makes it worth the MCE's investment in care coordination with the Partnership long term. The following programs will be made available to the staff hired for the LTSS CP with the hope they will stay throughout the project period and beyond. A sampling of some of the retention plans for staff includes:

- Tuition reimbursement/tuition discounts for staff seeking degrees at all levels
- 403 b contributions
- Involvement in professional growth and mentorship programs with senior leadership
- Vacation, Holiday and Personal Day pay
- Performance incentives of $500 when outcomes are met
- Emerging Leaders programs
- Opportunities for staff to move among the Partners for other positions with preferred staff status
- Full health insurance benefits
- Formal succession planning
- Referral incentives
- Work environments which promote creativity and value input
- Eligibility for bonus/holiday gift cards/Caught in the Act incentives
- Subsidized AAA and BJ memberships for all employees employed for 1 year
- Attendance at local and national conferences and workshops

F. Implementation Plan and Timeline

The Bidder shall attach timelines that display the Bidder's monthly implementation plans for the Preparation Budget Period, and quarterly implementation plans for each subsequent Budget Period. The timelines shall include all necessary operational activities to meet the Contractor Requirements described in Attachment A.

See attached timelines the display MCCN's monthly implementation plans for the Preparation Budget Period, and quarterly implementation plans for each subsequent Budget Period.

G. Budget Report and Budget Narrative

See Budget Report and Budget Narrative and the following Attachment B and Attachment C documents.

H. Sustainability (not to exceed 2 pages)

Pathway to Sustainability: Key Principles of Sustainability Models

During the five-year demonstration, MCCN will use DSRIP infrastructure funds to build its capacity to support start-up costs associated with the implementation of this new, integrated care management service line and partnership model. Year One will be a time of uncertainty, change, learning and relationship building.

MCCN's Initial Steps to Determining the Sustainability Model:

Upon award, MCCN will form a Financial Workgroup (one of three MCCN Committees) whose charge will be to develop a Sustainability Model. The following steps will inform the model.

1. Finalize care coordination model, case management software and roles of entities involved in delivering and overseeing care for Enrollees.
2. Identify and prioritize targeted care delivery and APM strategies with ACO/MCOs.
3. Build baseline administrative, medical and pay-for-performance key performance indicators and implement framework for monitoring and assessing metrics across all Partners.
4. Conduct comprehensive inventory of current cost structure and cost drivers of all Partners.
5. Catalog existing and projected sources of data, ability to manipulate data, and timeliness of data.

Building a Sustainability Plan

Once the tasks noted above are complete, MCCN's Finance Workgroup will focus sustainability planning efforts on four key tasks:

1. Build a 'straw model' 3-5 year budget/cost model that includes an estimated ROI. As part of the planning phase, a significant amount of DSRIP infrastructure funds will be used to develop and implement the new care management software. The development cost is a one-time expense. The annual, ongoing PMPM expense of maintain the software has been factored into the budget. Our sustainability model also takes into consideration that funding will be needed to key clinical staff to launch the program until such time that MCCN will engage its target number of 1500 Enrollees per region, anticipated at the end of Year Two. As the program continues to expand with the addition of Care Coordinators and other related staff, the need to rely on DSRIP funding will be largely reduced. Most of the care coordination strategies for Enrollees will focus on closing care

gaps and improving care delivery across the continuum of community providers. MCCN expects transformation will result in three basic changes– expansion of ambulatory care (particularly primary care); contraction of inpatient services; and increased need for community-based and care management services. Given this focus, it is anticipated that numerous changes will occur that will impact MCCN's caseload and resultant administrative costs and risk-based financial performance.

2. Once the 'straw-model' budget has been established, the Finance Workgroup will assess current resources and determine projected financial needs, including but not limited to clinical tools, systems, resources, training and infrastructure. As an early priority, MCCN is committed to finding opportunities to share resources and infrastructure, and MCCN leadership will begin early to address alignment and the potential phasing of that alignment (e.g. IT, staffing, human resources, finance, training, equipment, EHR, inter-operability), share best practices and identify collective payment strategies, while providing the most effective care to Enrollees.

3. Define potential savings and other financial strategies to pursue, including payment transformation that is aligned with the State's vision. MCCN's long-term sustainability plan will include the shift to increased reliance on value-based payments and ACO/MCO contracts that accurately reward efficiency, value, and managing across the care continuum. Our goal is to spend these five years understanding the MCEs and developing joint goals that will carry the MCCN forward in a shared risk relationship which will reduce costs, but will also continue the proven integrated supports that the MCCN offers to the MCEs for the care of their LTSS Enrollees. Two of the Partners have experience with APM (as mentioned earlier) and have successfully developed APM methodologies. The MCCN is interested in exploring the development of APMs during this project, understanding that this will make the Partnership more attractive to the MCEs in the long run.

4. Identify proposed financial performance metrics and key longitudinal milestones. Specifically, the sustainability plan will include:

    - Key metrics and milestones, by year, for MCCN to satisfy to stay financially viable and attain stated goals.
    - A management reporting process and timetable for comparing actual versus projected metrics/milestones for MCCN.
    - Specific reporting and monitoring of poor performance that will require oversight throughout the transformation process.

I. Quality Management and Performance Monitoring (not to exceed 3 pages)

The Bidder shall describe its plans to satisfy the quality management and quality improvement requirements, as described in Section 2.8 of Attachment A. Such description shall include:

1. A description of the Bidder's quality improvement program;

Central to an effective Quality Management Program is a commitment to achieving excellence, as demonstrated by Enrollee engagement, satisfaction and defined measures of success. Each

MCCN provider has within their existing structure advanced Quality Improvement models. Working together has afforded us the opportunity to examine various models and research from the Agency for Healthcare Research and Quality (AHRQ); studies on "Care Coordination in Managed Long Term Services and Supports (AARP Public Policy Institute); "Quality Indicators for Physical and Behavioral Health Care Integration" (JAMA), and Care Coordination Experiences of People with Disabilities Enrolled in Medicaid Managed Care (University of Chicago Department of Disability and Human Development). These studies have informed our approach to Quality Management and frame our direction for a robust and meaningful Quality Improvement Program.

Research clearly indicates that collaborative care models have demonstrated significant cost savings in low income, high risk populations with medical comorbidities as compared to traditional models of care. With a "triple aim" of achieving better care quality, improved population health, and more affordable health care, the delivery of well-coordinated and integrated health care services is paramount to success. First and foremost, then, is a Quality Improvement Program that relies on effective strategies that reinforce best practice and outcomes across ACOs, MCOs and Community Partners. Our efforts must be complementary not duplicative, with aligned quality measures and timely exchange of information and data to inform care planning. The MCCN recognizes the importance of this approach and is committed to quality management and performance that achieves the "triple aim".

To that end, MCCN will utilize a Continuous Quality Improvement (CQI) approach based on the CQI principles that incorporates a rapid Plan, Do, Check, Act cycle (PDCA). By implementing the PDCA cycle, we identify the quality initiative or problem to be solved, collect and review data, strategize as a team on solutions, implement the intervention, and, most importantly, check to determine if the desired outcome is being achieved, and take action to adopt, adapt or change. This model requires broad input from staff, supervisors, Enrollees, ACOs and MCOs.
We firmly believe that without staff and Partner "buy-in," the CQI process is something <u>others</u> do, and thus the results are limited. To be a truly effective CQI program, all parties/partners have to be involved and take responsibility for both quality and improvement activities.

The Quality Management Committee will fulfill the role of monitoring each area with a diverse representation including Enrollees, management, and Care Supervisors/Coordinators. The QM Committee will establish and maintain the MCCN Quality Improvement Plan, which will be approved by EOHHS. Specific and targeted population, healthcare, and cost outcome measures will be developed in concert with ACOs and MCOs, with methodology and frequency of reporting determined, taking into consideration the unique characteristics of each service area. Dashboards on the MCCN website will highlight the patient satisfaction outcomes. Measures of success will be determined based on the measure design principles of 1) keep it simple; 2) consider clinical, financial, and social outcomes; 3) align measures and reporting; and 4) consider a variety of measures that phase in over time. Overarching measures include:

<u>Process Measures:</u>

- Enrollees Assigned/Engaged/Disengaged
- Number and type of outreach and qualifying activities
- Documentation of Enrollee agreement and timeframe

- Development of LTSS Care Plan and timeframe
- Risk Assessments/Stratification
- Care Transitions
- Mode of Contact

Quality Outcomes:

- Quality of Life
- Chronic Disease Management
- Health Risks and Outcomes
- Caregiver Stress and Support
- Community Tenure
- Social Determinants of Health (housing stabilization, food security, basic needs, etc.)
- Adherence to Care Plan/Care Coordination
- Isolation/Connectedness/Social Networks
- Natural Supports/Family Unification

Enrollee Satisfaction:
Satisfied Enrollees are more likely to follow care plans, continue regular health services, seek continuity of care with specific provider(s) and disclose critical information. Consistent with CQI, narrowly focused question(s) with rapid results to impact change will be used:

- How likely are you to recommend MCCN?
- Experience of improved health/satisfaction with care coordination on self-assessment

Cost and Efficiency Outcomes:

- Productivity
- Revenue/Expense
- Total Cost of Care

2. A description of at least one quality initiative the Bidder proposes to undertake in the first year including measures for success; and

The MCCN envisions Year One of the project as a time of program development. Primary objectives will include utilization of case management software for data gathering and assessment of program activities, including Partner capabilities, population demographics, needs and costs, workforce development/training especially as it relates to effective care coordination; outreach; and engagement.

While these process measures are important in building program capacity, effectiveness and efficiency, the quality initiative that MCCN will focus on in Year One relates to caregiver stress. The impacts of stress on the mental health of caregivers have been estimated to be between 40-70% of all caregivers with clinically significant symptoms for depression (MIT Age Lab and AARP Public Policy Institute, 2014). Alleviating these stressors through effective care coordination is one way to strengthen the system.

The MCCN has chosen two brief, but effective evidence-based tools in order to assess caregiver stress during our first year of full operation. These tools, The Caregiver Self-Assessment Questionnaire developed by the American Medical Association and the Kingston Caregiver Stress Scale (2015) are easy to administer and brief to complete for the caregiver. Using a pre and post-test model, along with intermittent assessment as necessary, MCCN will assess caregiver stress to better understand and implement strategies to support caregivers. Caregivers will be those defined in the LTSS Care Plan.

Quality Initiative Goal: To reduce caregiver stress as perceived by the caregiver in areas related to perceived personal health; time management; personal freedom; worry; financial issues; hopelessness and anxiety.

Outcome Measure: A reduction in caregiver stress in at least 3 domains of life (based on a 5 point scale) for 60% of caregivers, as determined through self report.

3. The functions of the Bidder's quality management committee including the composition and reporting structure within the Bidder's organization.

MCCN will have one QM Committee with representation from each of the Affiliated Partners. Senior level quality management staff from each partner organization will comprise the Committee with at least one Care Manager/Coordinator, Enrollee, and community or healthcare representative included. Initially, the QM Committee will meet monthly to establish the Quality Improvement Plan, to be approved by EOHHS. Once established, the Committee will meet at least quarterly to monitor outcomes and report findings to the Governing Body. This data will then be gathered in the aggregate by the Lead Agency through the Director of Quality Management. The Director will have the responsibility of developing reports and reporting back to the Governing Body, Partners, Enrollees and families/caregivers.

J. Coordination with ACOs and MCO (not to exceed 2 pages)

1. How the Bidder will communicate the Bidder's skills, expertise, and value to potential ACOs and MCOs;

Each of the MCCN partners has current relationships with nearly all of the MCEs and has spent the last year meeting with them to help determine their joint care coordination thoughts and strategies. The MCEs readily admit that they are unsure of the LTSS population, not clear on their final data sharing software, and are looking to the CPs for expertise. These conversations included specifics about their population focus; innovative models; where they might be looking to realize savings on their TCOC; and how they anticipate exchanging health and utilization information in real time. During these conversations, MCCN Partners have detailed their deep understanding of the population, as well as the approach that the MCCN will be taking for care coordination and the exchange of information. Once the ACOs/MCOs are announced by MassHealth, the Partnership will send information to each entity outlining the population expertise of each Partner and a description of each agency's services and supports, as well as the anticipated approach of the MCCN should the award be made. Our overview will include our value proposition: our years of experience and success with the populations we support. We have already introduced MCCN to the MCEs which will expedite the contracting process once LTSS CP awards are made.

2. The Bidder's branding and marketing plan with respect to its relationships with ACOs and MCOs;

The MCCN is uniquely positioned to provide a strong value proposition: the agencies represented have decades of LTSS AND behavioral health supports. The Partners have long established connections to over 100 community-based supports and experts in the three regions and will market these connections in order to begin working with the MCEs to solve LTSS population challenges they may be facing. Each stakeholder comes at the value of the relationship differently. The CPs understand the population and the supports necessary to ensure the health of the members in the community. The MCEs understand the very different world of traditional hospital and physician culture. To improve health and overall costs of care, neither entity can be successful without the expertise of the other. Together, we can address the gaps in care and develop joint solutions that meet both of our bottom lines and improve health outcomes.

MCCN's Marketing Strategy to ACOs/MCOs

"Customers do not buy what you sell. They buy what has value to them" (Howard Gossage). The MCCN is selling knowledge and expertise with a population the MCEs struggle with. We are selling our case coordination skills which will enable our customers, the MCEs, to realize efficiencies enabling them to demonstrate to MassHealth that they have successfully met their outcomes. Within the first 30 days of a contract, the Partners will meet with the MCEs with whom they already have a relationship and will begin the discussion of how we might meet their LTSS care needs. During these conversations, we will reach consensus on shared mission, vision, goals, objectives and appropriate intervention strategy; cooperate to develop value propositions and clearly articulate MCCN's value as a critical partner to enable the mutual goals of the MCE and MCCN; present return-on-investment examples to illustrate efficacy; and clearly define and state roles and responsibilities of each Partner.

As this relationship evolves, our role will be based on the relationship we have developed with the MCEs. Once a month, the Director of Integrated Care Management will meet with the

ACO/MCO. In addition, an annual report on the MCCN's activities will be shared with MCE partners. As Partners, we will:

Branding & Marketing Plan with Relation to ACO/MCO
• Engage Partners in collaborative problem-solving of jointly shared problems • Identify and define linkages to community-based services • Discuss lessons learned on an ongoing basis to modify and strengthen partnership structure and processes. • Ensure transparent and frequent communication between Partners and other key stakeholders. • Create a common language and definitions for discussing approach • Focus on being transparent and candid • Provide a safe, respectful forum to discuss barriers and mechanisms to resolve conflicts • Build upon past partnership history to promote trust and communication

3. The Bidder's strategy to engage and collaborate with multiple ACOs and MCOs in the Services Areas for which the Bidder is bidding; and

The MCCN's goal is to be a resource to all MCEs in its three regions. Our conversations will center on their strategy for meeting the triple aim for their Enrollees and our part in managing their care so they can achieve that goal. We anticipate each MCE may have slightly different approaches to meeting those needs and we are prepared to have a flexible approach in our service delivery. Following an award from MassHealth, the MCCN will meet with each MCE and develop a contract that specifies the roles and responsibilities of the Partners and the MCE. This contract will help ensure there is full transparency in each Partner's role and will help to reduce any potential conflicts. At the beginning of the contract, the MCCN Partners will meet with each MCE and review their data: What do the trends show? Which population is the MCE struggling with the most? What areas of expertise do they most need and how might we fill that gap? If no data exists at the local level, then the MCCN Partners will work with the MCEs to gather and interpret community data in order to be better informed. Since data informs our decision making, finding multiple ways to share the data will be of paramount importance. Not only will we examine clinical data, but we will also examine data on administering the CP; results of our marketing campaigns and what potential Enrollees and their caregivers are telling us about outreach; our various IT systems and ease of exchanging information; and how ALL partners define quality and reach quality benchmarks. The MCEs want to ensure the MCCN is able to perform the tasks as set forth and is accountable for meeting the contract specifications. One of the strategies for the formation of the MCCN CP was the ability of the Partners to take on risk, share best practices and have the bandwidth to undertake a project of this scope. We know this five-year demonstration will go through multiple iterations. The MCCN will illustrate its value through the sharing of risk and development of APMs.

4. The Bidder's strategy for conflict resolution, should any conflicts arise between the Bidder and an ACO or MCO.

Our approach to conflict resolution is to communicate all expectations at the beginning of the process through a jointly developed MCE contract. For example, we would want to address how the following potential areas of conflict will be resolved in the contract:

Potential Areas of Conflict of Interest	Multi-Step Escalation Approach
• Contractual/financial issues • Compliance with laws and ethics • Technical issues such as IT performance • Clinical decisions and issues • Business operations and workflow • Data and reports (outcomes, utilization, costs)	• Lead meets with MCE to discuss/negotiate resolution • If this is not successful, an impartial mediator will be brought in to meet with both parties • If this is not successful, a formal arbitration path will be followed • The last resort would be legal action

K. Providing Culturally Competent and Informed Services and Supports (not to exceed 2 pages)

1. Describe how the Bidder will provide effective, equitable, understandable, and respectful quality supports that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy, and other communication needs, including:

a. How the Bidder will provide language/communication assistance (including access to qualified interpreters) for Enrollees with Limited English Proficiency, Deaf Enrollees, Enrollees who are Hard of Hearing, and Enrollees with cognitive disabilities;

The MCCN will make every effort to recruit staff that represent the diversity of the individuals served and deliver services in their primary language. The MCCN will recruit, promote and support a culturally and linguistically diverse workforce that is compatible to the population in the service areas. Our communities are known for their cultural diversity. For this reason, we have staff who are bicultural/bilingual. Positions in some programs require that staff is bilingual in order to accommodate our Enrollee needs. Languages our staff is fluent in include: Spanish, Portuguese, French, Cape Verdean, Creole and American Sign Language and the MCCN will have the services of the Ascentria Language Bank. We continually train current and new staff in cultural and racial sensitivity. The MCCN also has experience in working with individuals who utilize an augmentative and total communication approach. American Sign Language translator support will be available to those who are deaf or hard of hearing or for those who are nonverbal and use ASL to communicate. Additionally, individuals will be supported to use augmentative communication devices such as TTY's, voice output devices, letter boards, picture boards, Tobi communication systems, Dynavox communication systems, and IOS based communication apps. Any written information and documentation will be made available in the Enrollees' primary language.

b. How the Bidder will inform Enrollees of available language and communication assistance clearly and in their preferred language or format; and

Enrollees will be informed of available language and communication assistance upon referral and throughout the intake process. Once an Enrollee has been referred, the Intake/Outreach Coordinator will review the referral packet and Comprehensive Assessment to determine the Enrollee's preferred language and communication needs. When possible, a Care Coordinator will be assigned who is fluent in the person's preferred language. For those individuals requiring the use of communication devices, a Care Coordinator specially trained in utilizing these devices will be assigned. In the event MCCN staff do not have the language capacity, interpreter services will be utilized. Potential Enrollees will be informed of language and communication assistance through information packets and brochures that are translated into the spoken languages.

c. How the Bidder will provide supports in a manner responsive to diverse cultural beliefs and practices, including those related to an individual's race, ethnicity, disability, sexual orientation, and gender identity.

Culturally competent services include respectful recognition of the differing values and culture of the individual and includes, but is not limited to recognition of economic status, gender, sexual orientation, ethnicity, race, language and the unique values and goals of each individual. To ensure that effective care is provided, agency staff, supervisors and administrators will seek consultation and additional services when necessary to overcome barriers impacting the delivery of care. An Enrollee's perspective and knowledge of culture will be incorporated into the care planning process. Many people have a strong working understanding of how culture has influenced them, while others have a more limited knowledge and understanding. The care

coordination process must be sensitive to both perspectives, and encourage the Enrollees to identify cultural influences in their daily lives.

Cultural competency accepts and respects differences, emphasizes the dynamics and challenges arising from these cultural and linguistic differences in planning and delivering of services to diverse populations, and is committed to acknowledging and incorporating the following: importance of cultural awareness; respect, relate and respond to an individuals' culture in a non-judgmental, respectful and supportive manner; sensitivity to cultural diversity brought by a variety of factors including ethnicity, language, lifestyle, age, sexual preference, and societal status; access to non-traditional services; and adapting services to meet the specific cultural needs of the Enrollee.

2. **Describe the expertise and experience the Bidder has providing care to special populations, including but not limited to: a. Individuals experiencing homelessness; b. LGBTQ populations; c. Criminal Justice-involved individuals; d. Individuals who are blind, low vision, Deaf or hard of hearing; and; e. Individuals with cognitive disabilities.**

The MCCN has extensive experience proving care to the specialized populations below:

Specialty Population	Services Provided	Service Location
Individual Experiencing Homelessness	Aggressive Treatment and Relapse Prevention-provides housing and treatment, Helpline-housing support, drop in centers, HIV/STI Screening, Education and Testing/Narcan	Central and Southeast regions
LGBTQ Population	HIV/Case Management, HIV/STI Screening, Education and Testing/Narcan, Transgender Support Groups, Community Drop-in Centers, Mobile outreach	Southeast region
Criminal Justice-Involved Individuals	Jail Diversion, Re-entry Services, Community Based Flexible Supports (forensic program), DDS Forensic Residential Services, Relationship Ladders Training Program, Mental Health Provider - Worcester County Jail, HIV/STI Screening, Education and Testing/Narcan Distribution-Dartmouth House of Corrections, and Ash Street Facility.	Throughout many communities in the Central, Northeast and Southeast Regions
Individuals who are Blind or Deaf/Hard of Hearing	Residential, Day and Respite services who have I/DD and/or behavioral health needs.	Throughout many communities in the Central, Northeast and Southeast Regions
Individuals with Cognitive Disabilities	Memory Café, Alzheimer's Support groups, Brain Injury Survivors Group, Senior Service Coordination, Alzheimer's Certified Adult Day Health	Throughout many communities in the Central, Northeast and Southeast Regions

Community Partner Program Budget Report

WestMass ElderCare/Care Alliance of Western MA

Program Revenue	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Estimated Enrollees- Start of Period (All Enrollees)		500	1,000	1,250	1,500	1,750	
Estimated Enrollees - End of Period (All Enrollees)		1,000	1,250	1,500	1,750	2,000	
Estimated Enrollees - Monthly Average		750	1,125	1,375	1,625	1,875	
Total Estimated Program Revenue		**$ 420,000**	**$ 1,080,000**	**$ 1,320,000**	**$ 1,560,000**	**$ 1,800,000**	**$ 6,180,000**
At- Risk Withhold Rate			0%	0%	0%	0%	
Withhold funds			$ -	$ -	$ -	$ -	$ -
Revenue for Operations		$ 420,000	$ 1,080,000	$ 1,320,000	$ 1,560,000	$ 1,800,000	$ 6,180,000

	Program Expenses		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
1	**Salary**		$ 134,956	$ 410,066	$ 678,291	$ 792,615	$ 961,584	$ 1,090,129	$ 4,067,641.23
2	**Fringe**		$ 43,186	$ 131,221	$ 217,053	$ 253,637	$ 307,707	$ 348,841	$ 1,301,645.19
	Total Personnel Costs		$ 178,142	$ 541,288	$ 895,345	$ 1,046,251	$ 1,269,291	$ 1,438,970	$ 5,369,286
3	**Training & Professional Development**								$ -
4	**Travel**		$ 8,454	$ 13,505	$ 22,288	$ 26,289	$ 32,203	$ 36,702	$ 139,441
5	**Equipment**		$ 2,590	$ 2,849	$ 6,660	$ 7,548	$ 8,880	$ 9,768	$ 38,295
6	**Supplies**		$ 2,522	$ 3,025	$ 4,125	$ 4,675	$ 5,500	$ 6,050	$ 25,897
7	**Contract Services** (consulting, professional)			$ -					$ -
8	**Software licensing**				$ 20,000	$ 20,000	$ 20,000	$ 20,000	$ 80,000
9	**Telecommunications**		$ 2,840	$ 3,124	$ 4,261	$ 4,829	$ 5,681	$ 6,249	$ 26,984
10	**Occupancy** (rent, utilities, maintenance)		$ 15,208	$ 22,811	$ 44,319	$ 52,140	$ 46,924	$ 53,480	$ 234,883
11	**Other**		$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Total Direct Costs		$ 209,755	$ 586,602	$ 996,997	$ 1,161,732	$ 1,388,479	$ 1,571,219	$ 5,914,786
12	**Indirect Cost/Administrative Overhead**	**12.0%**	**$ 25,171**	**$ 70,392**	**$ 119,640**	**$ 139,408**	**$ 166,617**	**$ 188,546**	$ 709,774
	TOTAL EXPENSES		$ 234,926	$ 656,995	$ 1,116,637	$ 1,301,140	$ 1,555,096	$ 1,759,766	$ 6,624,560
	Surplus/Shortfall		*$ (234,926)*	*$ (236,995)*	*$ (36,637)*	*$ 18,860*	*$ 4,904*	*$ 40,234*	*$ (444,560)*

Ramp-up costs in Prep Budget Period, Budget Year 1, 2 and 3 can be covered by Infrastructure Funding

ElderCare / CAWM Community Partner Program Budget Report - Prep Bu

Only complete this Program Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Program Budget Narrative tables as necessary

Row 1 - Salary

Position	Annual Salary	FTEs	# Months	Total
Program Director	75,000.00	0.60	7.00	26,250.00
Bookkeeper/Billing Specialist	42,000.00	1.00	3.00	10,500.00
I & R Specialist	38,000.00	1.00	3.00	9,500.00
Systems & Quality Analyst	72,800.00	0.57	7.00	24,206.00
Care Coordinators	43,000.00	6.00	3.00	64,500.00
				-
				-
Total Salary (Program Budget Line 1)		**9.17**		**$ 134,956.00**

Row 2 - Fringe

Fringe Item	Total Salary	Fringe Rate	Fringe
Fringe Item	$ 134,956.00	32%	$ 43,185.92
Total Fringe (Program Budget Line 2)			**$ 43,186**

#VALUE!

Total Personnel*	**$ 178,142**

* Should align with Personnel Costs row in Program Budget

For each position listed above, provide a brief statement of the position's responsibilities:

Program Director: is responsible for training, directing, and monitoring the Care Coordinators in providing appropriate and quality services to enrollees according to the procedures of WestMass ElderCare and the regulations of the Executive Office of Health and Human Services. Referrals are treassed to partners under his/her direction.

Bookkeeper/Billing Specialist: responsibilities include billing for the LTSS CP program and then reconciling payments.

I & R Specialist :The Information and Referral Specialist shares responsibilities with the Information and Referral Supervisor for WMEC's activities related to the maintenance and dissemination of information regarding services and programs available to consumers. She/he holds a central position in directing intakes, assessments, counseling and referral of consumers and their caregivers who require information and/or services.

Care Coordinators: The LTSS CP Care Coordinator engages in activities designed toward eliminating barriers and improving the conditions and well-being of enrollees. The Care Coordinator is an integral component of the community care and long-term care management system for enrollees. She/he engages in activities, which incorporate a variety of disciplines and funding sources. The Care Coordinator is directly involved in the processes of assessment, service planning and coordination, advocacy, problem solving, and gatekeeping.

Each member of the consortium/affiliated partner will contribute 1/8 of the Care Coordinators for a cost of $8,062.50 per partner for salary and $2,580 for fringe.

System & Quality Analyst :Responsible for all facets of quality and compliance for the Long Term Support Services – Community Partner program (LTSS CP) of the Care Alliance of Western Mass (CAWM). Develop the CAWM Quality Management Committee; assist in the development and implementation of the CAWM CQI program; responsible for all quality reporting and interpreting data to all customers, both internal and external. Coordinate and facilitate system enhancements, as appropriate.

Fringe: Buget for all unfilled positions assumes family health and dental insurance. Actual fringe may be lower if significant number of

Row 3 - Training and Professional Development

Description of Service	Unit Cost (if applicable)	# Staff (if applicable)	Total Cost
Total Training and Professional Development (Program Budget Line 3)			

Provide a description of each Training and Professional Development line item included in the table above:

Row 4 - Travel

Position	Est miles per month	# months	Mileage reimbursement rate	Total Cost
Program Director	535	7	0.535	$ 2,003.58
6 Care Coordinators	2280	3	0.535	$ 3,659.40
Systems & Quality Analyst	625	7	0.535	$ 2,340.63
			Total Mileage	$ 8,003.60

Travel Expense Description	Cost
Total Mileage	$ 8,003.60
Parking and tolls	$ 450.14
Public transportation	
Enrollee travel	
Total Travel (Program Budget Line 4)	**$ 8,453.74**

Please describe how mileage estimates and other travel expenses listed above were determined . If including enrollee travel expenses above, please explain how these expenses will be used by enrollees.

Travel assumes staff will be attending trainings off site or at various community partner locations

Parking and tolls assume:
9 trips to Boston for meetings ($9 in tolls and $28 parking fee) at a cost of $296.
Mass Pike tolls for Care Coordinators, Program Director and Quality Analyst to attend meetings and trainings at partner agencies $117.

Each member of the consortium/affiliated partner will contribute 1/8 of the Care Coordinators travel expenses or $457.43 per partner.

Row 5 - Equipment

Description of Equipment	Unit Cost	#units or FTEs	Cost
Computer Rental	259	10.00	$ 2,590.00
Total Equipment (Program Budget Line 5)			**$ 2,590.00**

Provide a brief description of the intended use for each Equipment line item listed above and how the estimated costs were determined:

Computer rental at $37 per month * 7 months * Units needed

Each member of the consortium/affiliated partner will contribute 1/8 of the Care Coordinators computer expenses or $211.83 per partner.

Row 6 - Supplies

Description of Supplies	Unit Cost or Cost/FTE	# Units or FTE	Cost
Office Supplies / Printed Material	275	9.17	$ 2,521.75
Total Supplies (Program Budget Line 6)			

Provide a brief description of the intended use for each Supply line item listed above and how the estimated costs were determined:

Office supplies/ Printed Material costs were estimated a t $275 per FTE.

Office Supplies inclued: printed materials describing program, paper clips, paper, staples, toner for printer and fax machines along with laptop bag for each Care Coordinator.

Each member of the consortium/affiliated partner will contribute 1/8 of the Care Coordinators supplies expenses or $206.25 per partner.

Row 7 - Contract Services

Name of Contractor	Contractor Type	Goods and Services Provided	Cost
Total Contract Services (Program Budget Line 7)			

Provide a brief description of the purpose/need for each Contractor line item listed above, how each will support the CP's performance and how the costs for each were determined. Note that a Statement of Work must also be submitted to EOHHS.

Row 8 - Software Licensing

Description of Software	Cost per License	# Licenses	Cost
		Total Software Licensing (Program Budget Line 8)	

Provide a brief description of how each Software Licensing line item listed above will support the CP's performance and how the costs were determined:

Row 9 - Telecommunications

Type of Service Plan	Cost per Employee	Employees	Cost
Telephone Cost	284.04	10	$ 2,840.40
		Total Telecommunications (Program Budget Line 9)	**$ 2,840.40**

Provide a brief description of how each Telecommunications line item listed above will support the CP's performance and how the costs were determined:

telecomm expenses are determined by taking total land line and cell phone costs divided by employees at agency.

Telecomm costs in budget are for a 7 month time frame or $40.58 per month per employee.

Care Coordinators will have access to cell phones they can sign out as needed.

Each member of the consortium/affiliated partner will contribute 1/8 of the Care Coordinators telecomm expenses or $232.31 per partner.

Row 10 - Occupancy

Occupancy Expense	Total SqFt	Cost/SqFT	Cost	
Rent	1580	13	$ 20,540.00	** Annual
Utilities	1580	2.33	$ 3,681.40	** Annual
Repair and Maintenance	1580	1.17	$ 1,848.60	** Annual
			$ -	
			$ -	
Total Occupancy (Program Budget Line 10)			**$ 15,207.50**	** Rent for 7 months

Provide a brief description of how each Occupancy line item listed above will support the CP's performance and how the costs were determined:

SqFt calculation:
158 sq. ft. per employee * # employees in program

Total in Budget line 10 is for seven monhts rent.

Each member of the consortium/affiliated partner will contribute 1/8 of the Care Coordinators occupancy expenses or $1,243.80 per partner.

Row 11 - Other

Other Direct Expense Description	Cost
Total Other Direct Costs (Program Budget Line 11)	

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Row 12 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead	**12.00%**	**$ 25,170.64**

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Based On WestMass ElderCare's historical administrative / Overhead costs.

Each member of the consortium/affiliated partner will contribute 1/8 of the Care Coordinators Indirect costs or $2,005.88 per partner.

WestMass ElderCare / CAWM Community Partner Infrastructure Budget Report

		WestMass ElderCare/Care Alliance of Western MA						
Infrastructure Investment Funding		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
	PMPM Infrastructure Rate		$ 75.00	$ 49.72	$ 43.28	$ 36.40	$ 29.34	
	Engaged Enrollees		1,000	1,000	1,250	1,500	1,750	
	Estimated Infrastructure Funds		$ 525,000	$ 596,640	$ 649,200	$ 655,200	$ 616,140	**$ 3,042,180**
	At- Risk Withhold Rate			25%	44%	63%	81%	
	Withhold			$ 149,160	$ 285,648	$ 412,776	$ 499,073	**$ 1,346,657**
	TOTAL MAXIMUM FUNDS AVAILABLE	$ 450,000	$ 525,000	$ 447,480	$ 363,552	$ 242,424	$ 117,067	**$ 2,145,523**
	Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
	Technology							
1	**IT Staffing including Fringe**	$ 54,120	$ 35,000	$ 30,000	$ 30,000	$ 30,000	$ 30,000	**$ 209,120**
2	**Development Adaptation of EHR and/or Care Management System**	$ 118,559	$ 213,000	$ 34,400	$ 34,400	$ 34,400	$ 34,400	**$ 469,159**
3	**Technology for Service Delivery**		$ -	$ -	$ -	$ -	$ -	**$ -**
4	**Other Technology Expenses**							**$ -**
	Total Technology	$ 172,679	$ 248,000	$ 64,400	$ 64,400	$ 64,400	$ 64,400	**$ 678,279**
	Workforce Development							
5	**Workforce Development staffing including Fringe**			$ -	$ -	$ -	$ -	**$ -**
6	**Recruitment Expenses**	$ 4,351		$ -	$ -	$ -	$ -	**$ 4,351**
7	**Training Expenses**	$ 15,000	$ 25,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	**$ 80,000**
8	**Retention Expenses**	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
	Total Workforce Development	$ 19,351	$ 25,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	**$ 84,351**
	Business Start Up Costs							
9	**Office Equipment (PBP & BP1 only)**	$ -	$ -					**$ -**
10	**Office Furniture (PBP & BP1 only)**	$ -	$ -					**$ -**
11	**Ramp-up Costs (PBP BP1, BP2 and BP3 only)**	$ 234,926	$ 236,995	$ 36,637	$ -			**$ 508,557**
	Total Business Start Up Costs	$ 234,926	$ 236,995	$ 36,637	$ -	$ -	$ -	**$ 508,557**
	Operational Infrastructure							
12	**Operation Staffing including Fringe**							**$ -**
13	**Other Operational Expenses**							**$ -**
	Total Operational Infrastructure	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
14	**Indirect Cost/Administrative Overhead Rate** 12.0%	$ 23,044	$ 32,760	$ 8,928	$ 8,928	$ 8,928	$ 8,928	**$ 91,516**
	TOTAL INVESTMENTS	**$ 450,000**	**$ 542,755**	**$ 119,965**	**$ 83,328**	**$ 83,328**	**$ 83,328**	**$ 1,362,703**

	A	B	C	D	E
1	**Community Partner Infrastructure Budget Report - Technology - Prep Budget Period**				
2	*Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.*				
3	*Lines may be added to the Infrastructure Budget Narrative tables as necessary*				
4	**Row 1 - IT Staffing including Fringe**				
5	**Position**	**Annual Salary**	**FTEs**	**# Months**	**Total**
6	IT Project Manager	82000	1	6	41000
7					
8					
9					
10					$ -
11					$ -
12					$ -
13					$ -
14					$ -
15		Total Salary	1		$ 41,000
16		Fringe rate	32.0%	Total Fringe	$ 13,120
17				**Total IT Staffing including Fringe**	**$ 54,120**
18				**(Infrastructure Budget Line 1)**	
19					
20	***For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the***				
21	***terms of the CP's contract:***				
22					
23	***IT Project Manager will be hired to help select EHR. Selecting EHR includes reviewing software quotes and negotiating licensing***				
24	***agreement. Once EHR has been selected Project manager will work with software vendor and CAWM to setup and configure***				
25	***software to meet our needs. IT Project manager will be responsible for identifying and coordinating any software customizations***				
26	***required for project along with negotiating any enhancements to software. PRoject manager will be working full time on project.***				
27					
28					
29					
30					
31	**Row 2 - Development/Adaptation of EHR and/or Care Management System**				
32	**Description of Expense**	**Cost**			
33	EHR Software	$ 118,559			

	A	B	C	D	E
34					
35					
36					
37					
38					
39	**Total Development and Adaptation of EHR and Care**				
40	**Management System**	$ 118,559.00			
41	**(Infrastructure Budget Line 2)**				
42					
43	***Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract***				
44	***and how the costs were determined:***				
45					
46	***Deposit on EHR software which will be operational on 5/1/2018. The balance will be paid in budget year one.***				
47					
48	***The above estimate is based on a current quote from*** **Annkissam software. The CAWA has not signed a contract with Annkissam and**				
49	**may go with another vendor if we can't agree on terms or support.**				
50					
51					
52					
53					
54					
55					
56					
57					
58	**Row 3 - Technology for Service Delivery**				
59	**Description of Expense**	**Cost**			
60					
61					
62					
63					
64					
65					
66	**Total Technology for Service Delivery**				

	A	B	C	D	E
67	**(Infrastructure Budget Line 3)**				

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Row 4 - Other Technology Expenses

Description of Expense	**Cost**
Total Other Technology Expenses (Infrastructure Budget Line 4)	

Provide a description of each IT line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Workforce Development - Prep Budget Period

Row 5 - Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe (Infrastructure Budget Line 5)	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 6 - Recruitment Expenses

Description of Expense	Cost
Advertising / Recruitment	$ 4,351.00
Total Recruitment Expenses (Infrastructure Budget Line 6)	**$ 4,351.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

9.2 FTE staff will be recruited by the CAWM. Recruitment expenses are itemized as follows: $322.93 per FTE for interviewing and selection costs and $150.00 per FTE for advertising; total recruitment costs will be $472.93 per FTE, totaling $4351.

Row 7 - Training Expenses

Description of Expense	Cost
Person Centered Care Planning	$ 6,000.00
Cultural Competency	$ 4,000.00
EHR Training	$ 5,000.00
Total Training Expenses (Infrastructure Budget Line 7)	**$ 15,000.00**

Provide a description of each training expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

DSRIP funding will be utilized to train and orient all new staff and certain existing staff in: cultural competency, accessibility and accommodations, independent living and Recovery principles, motivational interviewing, conflicts of interest, health and wellness principles, and other areas, as appropriate, to prepare staff to implement the CP program successfully
.In addition, training for CP Care Coordinators and supervisory staff will include training and certifications in Person-Centered Planning processes and MassHealth State Plan LTSS and eligibility criteria.

Training Expenses: 9.17 FTEs will be trained for the LTSS CP program at cost of $1,630.43 per FTE. Training expenses include the fees of the trainer(s), travel expenses for the trainer

Row 8 - Retention Expenses

Description of Expense	Cost

	A	B	C	D	E
199					
200					
201					
202					
203					
204	**Total Retention Expenses**				
205	**(Infrastructure Budget Line 8)**				
206					
207	***Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of***				
208	***the CP's contract and how the costs were determined:***				
209					
210					
211					
212					
213					
214					
215					
216					
217					
218					
219					
220					
221					
222					
223	**Community Partner <u>Infrastructure</u> Budget Report - Business Start Up Costs - Prep Budget Period**				
224					
225	**Row 9 - Office Equipment**				
226	Description of Expense	Cost			
227					
228					
229					
230					

	A	B	C	D	E
231					
232					
233	**Total Office Equipment**				
234	**(Infrastructure Budget Line 9)**				
235					
236	***Provide a description of purpose for each office equipment expense listed in the tables above, including how the costs were***				
237	***determined:***				
238					
239					
240					
241					
242					
243					
244					
245					
246					
247					
248					
249					
250					
251					
252	**Row 10 - Office Furniture**				
253	Description of Expense	Cost			
254					
255					
256					
257					
258					
259					
260	**Total Office Furniture**				
261	**(Infrastructure Budget Line 10)**				
262					
263	***Provide a description of purpose for each office furniture expense listed in the table above, including how the costs were determined:***				

	A	B	C	D	E
264					
265					
266					
267					
268					
269					
270					
271					
272					
273					
274					
275					
276					
277					
278					
279	**Community Partner Infrastructure Budget Report - Operational Infrastructure - Prep Budget Period**				
280	**Row 12 - Operational Staffing including Fringe**				
281	**Position**	**Annual Salary**	**FTEs**	**# Months**	**Total**
282					
283					
284					
285					
286					$ -
287					$ -
288					$ -
289					$ -
290					$ -
291		Total Salary	0		$ -
292		Fringe rate	32.0%	Total Fringe	$ -
293				**Total Program Staffing including Fringe**	**$ -**
294				**(Infrastructure Budget Line 12)**	

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in meeting the terms of the CP's contract:

Row 13 - Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses (Infrastructure Budget Line 13)	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in meeting the terms of the CP's contract and how the costs were determined:

Community Partner Infrastructure Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Row 14 - Indirect Cost/Administrative Overhead

Indirect Cost/Administrative Overhead	Rate	Total Indirect Cost
Total Indirect Cost/Administrative Overhead (Program Budget Line 14)	12.00%	$ 23,044.00

Provide a brief description of each line item listed above will support the CP's performance and how the costs were determined:

Based On WestMass ElderCare's historical administrative / Overhead costs.

	A	B	C	D	E
359					
360					
361					
362					
363					
364					
365					

Consortium Entity or Affiliated Partner

WestMass ElderCare/Care Alliance of Western MA

Infrastructure Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Infrastructure Funding
TOTAL FUNDS AVAILABLE	$ 450,000	$ 525,000	$ 447,480	$ 363,552	$ 242,424	$ 117,067	$ 2,145,523
Infrastructure Investment Projects	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Technology							
WestMass ElderCare Inc	$ 172,679	$ 248,000	$ 64,400	$ 64,400	$ 64,400	$ 64,400	$ 697,720
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Technology	$ 172,679	$ 248,000	$ 64,400	$ 64,400	$ 64,400	$ 64,400	$ 678,279
Workforce Development							$ -
WestMass ElderCare Inc	$ 19,351	$ 25,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 84,351
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consortium Entity or Affiliated Partner	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Workforce Development	$ 19,351	$ 25,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 84,351
Business Start Up Costs							$ -
WestMass ElderCare Inc	**$ 129,926**	$ 79,394	$ 10,991.06				$ 220,311
Adlib	$ 15,000	$ 22,514	$ 3,663.69	$ -	$ -	$ -	$ 41,178
Behavioral Health Network	$ 15,000	$ 22,514	$ 3,663.69				
Elder Services of Berkshire County	$ 15,000	$ 22,514	$ 3,663.69				
Greater Springfield Senior Services	$ 15,000	$ 22,514	$ 3,663.69				
Highland Valley Elder Services	$ 15,000	$ 22,514	$ 3,663.69	$ -	$ -	$ -	$ 41,178
LifePath	$ 15,000	$ 22,514	$ 3,663.69	$ -	$ -	$ -	$ 41,178
Stavros	$ 15,000	$ 22,514	$ 3,663.69	$ -	$ -	$ -	$ 41,178
Business Start Up Costs	$ 234,926	$ 236,995	$ 36,637	$ -	$ -	$ -	$ 508,558
Operational Infrastructure							$ -
WestMass ElderCare Inc							
Adlib							
Behavioral Health Network							
Elder Services of Berkshire County							
Greater Springfield Senior Services							
Highland Valley Elder Services		$ -	$ -	$ -	$ -	$ -	$ -
LifePath		$ -	$ -	$ -	$ -	$ -	$ -
Stavros		$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL INVESTMENTS	$ 426,956	$ 509,995	$ 111,037	$ 74,400	$ 74,400	$ 74,400	$ 1,271,188

WestMass ElderCare / CAWM Community Partner Milestones Report

Infrastructure Category	Infrastructure Investment Project	Project Goal	Goal Start Date	Anticipated Goal End Date	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
					Anticipated Milestone Target by 3/31/18	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:	Anticipated Milestone Target by End of PBP (5/31/18)	Evidence of Success	Has Milestone been met? (Y/N)	If NO, please explain:
Technology	IT Staffing inlcuding Fringe	Hire IT Project Manager	10/01/17	12/07/17								
Technology	Development and Adaptation of E.H.R/Care Management System	Purchase a EHR for CAWM members	10/01/17	01/08/18								
Technology	Development and Adaptation of E.H.R/Care Management System	EHR Operational	01/08/18	05/01/18								
Technology												
Workforce Development	Training Expenses	Prepare staff to inplement LTSSCP project	01/01/18	05/31/18								
Workforce Development												
Workforce Development												
Workforce Development												
Business Start Up Costs	Ramp-up Costs	Hire Care Coordinators	01/15/18	03/15/18								
Business Start Up Costs	Ramp-up Costs	Hire Program Director	10/01/17	11/01/17								
Business Start Up Costs	Ramp-up Costs	Hire I&R Specialist	11/01/17	12/01/17								
Business Start Up Costs												
Business Start Up Costs												
Business Start Up Costs												
Operational Infrastructure	Operation Staffing including Fringe	Hire Systems and Quality Analyst	09/01/17	11/01/17								
Operational Infrastructure												
Operational Infrastructure												
Operational Infrastructure												

Section 7.5 Initial DSRIP Participation Plan Revised 12-5-17

WestMass ElderCare's response to this **Section 7.5** constitutes the Initial DSRIP Participation Plan as described in **Section 4.1** of **Attachment A.**

A. Executive Summary **(not to exceed 2 pages)**

WestMass ElderCare's five (5) year business plan for implementing the LTSS CP program is as follows:

The mission of the Care Alliance of Western Massachusetts (CAWM) is to efficiently and effectively achieve the objectives of the Long-Term Services and Supports Community Partners Program in the four counties of Western Massachusetts and in the Athol, MA service area. The aim of the CAWM is to mitigate the divide that exists between providers of LTSS care due to lack of information-sharing, coordination, and knowledge, leaving members unserved or underserved.

Specifically, the CAWM has structured itself to deliver integrated LTSS care coordination that provides the:

- highest quality member experience,
- is accessible to the member and the family,
- is the most appropriate level of care in the most appropriate setting (the right care at the right time in the right place)
- is person-centered,
- is efficient and non-duplicative,
- supports community-first and independent living values, and
- is culturally competent.

1. In order to provide effective LTSS care coordination, the CAWM must actualize the following goals:

- improve collaboration, communication, cooperation and understanding between ACOs, MCOs, CPs, BH, LTSS, and the physical health systems
- make investments in technology and information to improve the LTSS infrastructure
- install a Quality Management Program that sets specific, high and measurable quality standards for each of above stated components of optimal LTSS care coordination; manage to these standards (Expect and Inspect).

2. The CAWM has the geographic reach, covering all of the counties of Western Massachusetts, and the service capacity, to serve the entire LTSS estimated focus population of 4159 clients in the Western Region and 138 in the Central Region. However, the Alliance built its budget projections based on serving a total 2,000 members over the five year period with the understanding there will be other LTSS CP providers in Western Massachusetts.

3. The CAWM has structured itself with Behavioral Health providers, Aging, Disability and other providers of LTSS to facilitate the information, knowledge and experience exchange necessary to best meet the complex care coordination needs of those we seek to serve.

A priority goal for the CAWM will be to continue to deepen relationships with ACOs/ MCOs and the health system to find ways of working together that will meet our shared vision of excellence in care coordination. A challenge for the CAWM will be to establish the information systems that provide reliable data to be shared with our partners, to demonstrate how the work that we do can mitigate the negative impact of the social determinants of health.

4. LTSS CP Program Implementation Plan and Time Frames: **This section was been revised on 12-5-17.**

Phase 1

Activity	Time Frame
Implement LTSS CP marketing strategy/plan	11/17
Initiate infrastructure enhancements/engage consultant for EHR RFR	12/17
Grow community partnerships	12/17

Define Program Operations/Policies/Procedures	12/17
Develop Quality Standards/Metrics/ Install CAWM Quality Committee	1/18
Execute ACO/MCO contractual agreements	1/18
Implement staffing plan/begin recruitment	1/18
Phase 2 June 1, 2018	
Accept Assigned Enrollees/Initiate Care Coordination	6/18
Create Consumer Advisory Committee	8/18
Manage caseload up to 1000 enrollees	12/18
Refine Sustainability Plan	12/18
Year 2: Jan 1, 2019	
Perform Comprehensive Quality Review of Program	3/19
Retool/revise operations based on lessons learned	ongoing
Grow community partnerships, hold LTSS CP Summit	5/19
Realign and refine CAWM structure/membership, as needed.	ongoing
Annual audit, revise, retool and apply course corrections as needed.	ongoing
Serve 1250 members at minimum	12/19
Year 3: Jan. 2020	
Initiate sustainability plan	1/20
Grow community partnerships and CAWM membership	ongoing
Continue to strengthen ACO/MCO partnerships/join ACO(s)	4/20
Grow community partnerships, hold LTSS CP Summit	5/20
Execute MCO contract(s)	7/20
Continue monitor progress against stated goals and quality metrics	monthly
Engage with ACO(s) to discuss resource needs	12/20
Annual audit, revise, retool and apply course corrections as needed.	12/20
Serve 1500 members, at minimum	12/20
Year 4: Jan. 2021	
Grow community partnerships and CAWM membership	ongoing
Continue to strengthen ACO/MCO partnerships	ongoing
Increase ACO membership(s) as needed	ongoing
Continue monitor progress against stated goals and quality metrics	monthly
Grow community partnerships, hold LTSS CP Summit	5/21
Engage with ACO(s) to discuss resource needs	12/21
Annual audit, revise, retool and apply course corrections as needed.	12/21
Serve 1750, at minimum	
Year 5: Jan. 2022	
Grow community partnerships and CAWM membership	ongoing
Continue to strengthen ACO/MCO partnerships	ongoing
Grow community partnerships, hold LTSS CP Summit	5/22
Execute MCO contract(s)	7/22
Continue monitor progress against stated goals and quality metrics	monthly
Engage with ACO(s) to discuss resource needs	12/22
Annual audit, revise, retool and apply course corrections as needed.	12/22
Serve 2000 members, at minimum	12/22
Perform evaluation of 5 year program experience	2/23

CSA Budget Report

Brockton Area Multi-Services, Inc. (BAMSI)

Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites	1	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate	NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)	77	85	93	102	112	123	
Estimated Funds	$ 84,948.00	$ 59,500	$ 39,060	$ 30,600	$ 29,568	$ 14,760	**$ 258,436**
At- Risk Withhold Rate			5%	10%	15%	20%	
Withhold			$ 1,953	$ 3,060	$ 4,435	$ 2,952	**$ 12,400**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 84,948.00	$ 59,500	$ 37,107	$ 27,540	$ 25,133	$ 11,808	**$ 246,035.80**

Investment Projects	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Project 1 Name: Online Video Training							
DSRIP Goal(s) Addressed: Goal 1:	*Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination process for ICC-Engaged Members and their families*						
Goal 2							
Goal 3:							
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ 10,000	$ 4,000	$ 3,000	$ 2,000	$ 1,000	$ 500	**$ 20,500**
Retention Expenses		$ 1,000	$ -	$ -	$ -	$ -	**$ 1,000**
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 1 Total	$ 10,000	$ 5,000	$ 3,000	$ 2,000	$ 1,000	$ 500	**$ 21,500**
Project 2 Name: Helpline at the Village: Pediatric Outreach and Partnership							
DSRIP Goal(s) Addressed: Goal 1:	*Fostering strong intergration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*Improving timely access to ICC services for children eligible to receive ICC and their families*						
Goal 3:							
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ 1,500	$ -	$ -	$ -	$ -	$ -	**$ 1,500**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ 1,022	$ -	$ -	$ -	$ -	$ -	**$ 1,022**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure							
Operation Staffing including Fringe	$ 3,823	$ 5,386	$ 14,100	$ 6,740	$ 6,740	$ 6,740	**$ 43,529**
Other Operational Expenses	$ 5,803	$ 869	$ -	$ -	$ -	$ -	**$ 6,672**
Project 2 Total	$ 12,148	$ 6,255	$ 14,100	$ 6,740	$ 6,740	$ 6,740	**$ 52,723**
Project 3 Name: Wraparound Strength Based Electronic Record							
DSRIP Goal(s) Addressed: Goal 1:							
Goal 2:	*Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination process for ICC-Engaged Members and their families*						
Goal 3:	*Improving timely access to ICC services for children eligible to receive ICC and their families*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ 42,598	$ 13,000	$ 3,000	$ 1,000	$ 1,000	$ 1,000	**$ 61,598**
Technology for Service Delivery	$ 11,440	$ -	$ -	$ -	$ -	$ -	**$ 11,440**
Other Technology Expenses		$ -	$ 1,000	$ 1,000	$ 1,000	$ 1,000	**$ 4,000**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**

Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 3 Total		$ 54,038	$ 13,000	$ 4,000	$ 2,000	$ 2,000	$ 2,000	**$ 77,038**
Total Project Costs		$ 76,186	$ 24,255	$ 21,100	$ 10,740	$ 9,740	$ 9,240	**$ 151,261**
Indirect Costs/ Administrative Overhead Rate	11.5%	$ 8,761	$ -	$ -	$ -	$ -	$ -	**$ 8,761**
Investment Projects Total		$ 84,948	$ 24,255	$ 21,100	$ 10,740	$ 9,740	$ 9,240	**$ 160,023**

CSA Budget Report - Budget Narrative Prep Budget Period

CSA Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name:Online Video Training Library

DSRIP Project Goal(s):

1

2 *Strengthen fidelity to Wraparound processes, including care planning, care management, and care coordination for ICC Engaged Members and their families.*

3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
		Total Salary	0	$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Helpline at the Village - Pediatric Outreach and Partnership

DSRIP Project Goal(s):

1 *Foster integration with ACOs/MCOs and primary care providers for ICC Engaged Members and Strengthen fidelity to Wraparound processes, including care planning, care management, and care coordination for ICC engaged members and their families*

2

3 *Improve timely access to ICC services for children eligible to receive ICC and their families*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
		Total Salary	0	$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name: Wraparound Strength-Based Electronic Record

DSRIP Project Goal(s):

1

2 *Strengthen fidelity to Wraparound processes, including care planning, care management, and care coordination for ICC Engaged Members and their families.*

3 *Improve timely access to ICC services for children eligible to receive ICC and their families*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
		Total Salary	0	$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Program Consultant - eHana	$ 31,608.00
ehana license and implementation Fees	$ 10,990.00
Total Development and Adaptation of EHR and Care Management System	$ 42,598.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:
Fee for eHana programming & development of electronic enhancements consistent with Wraparound language and EOHHS goal of secured mechanisms to support data exchange.

Program Consultant eHana: Programming & Development Team: $31,598 will be paid to eHana for:
1) $5,000 Mass HiWay integration (projects & licenses);
2) $3,000 CANS Interoperability (shared with other CSAs);
3) $8,000 for Wraparound documentation development (shared with other CSAs);
4) $5,000 CSA quality and accountability measures reporting (shared with other CSAs); and
5) $10,608 (59 hours of eHana staff time at a rate of $180.00 per hour). Professional Fees: project management, business analysis, training, and development support plan.

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	**$ -**

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	**$ -**

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	**$ -**

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Database for Improved Tracking	$ 1,500.00
Total Other Technology Expenses	**$ 1,500.00**

***Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how*Enhanced Tracking Database:**

Database Name: MS Access
Utilization: This tool will be used to track persons served demographics, service needs, service outcomes, gaps, license purchase, etc.
Who: The CSA Outreach Coordiantor will be able to monitor referrals from community pediatricians.
Cost: The BAMSI charge back for IT services is $50..0per hour. It is estimated the database will take 30 hours to build and test. **($1,500.00)**

eHana License and Implementation Fees: During the Preparation Budget period an investment of **$10,990** will purchase the eHana CSA module **($5,000.00)** license and pay for implementation fees**($5,040.00**; 28 hours at $180.00 per hour) eHana IT staff time associated with bringing the electronic record online at the BAMSI CSA.

Technology for Service Delivery

Description of Expense	Cost	
Purchase Surface pros - 11	**$ 8,800.00**	8800
IT set-up per device	**$ 2,090.00**	2090
Verizon Monthly Service	**$ 550.00**	550
Total Technology for Service Delivery	**$ 11,440.00**	

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:
Surface Pros for CSA staff to support community-based work during care plan team meetings. Surface Pros will include video conferencing and data exchange with ACOs/MCOs and others as needed.
Purchase 11 Surface Pros for CSA staff to remotely access the elctronic record while working with youth and families: The Devices will support a total of 17 FTEs.
*There will be 3 additonal devices to support additonal ICC and FPs (3 FTEs) given increased census as needed.

Surface Pros: ($800 plus $190 for IT support to set-up/install programs per device).
IT chargback is $50.00 per hour. It is estimated that each device will take approximately 4 hours for set-up (loading programs/applications, software, malware, gps, etc). **$190.00** will allow for 3.8 hours per device.

$10.00 monthly service charge **X** 11 devices **X** 5-month PBP = $550.00 for Verizon Internet when staff are in the field.

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	**$ -**

CSA Budget Report - Workforce Development - Prep Budget Period

Project 1 Name: Online Video Training

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -

Project 2 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -

Project 3 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -

Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	**$ -**

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Cost of (1) Production Day	**$ 3,200.00**
Post Production of Videos & Manual	**$ 4,800.00**
Reflective Supervision Training (6 FTEs)	**$ 2,000.00**
Total Training Expenses	**$ 10,000.00**

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Investments in this project during the Preparation Budget period include:

1)Contracting with ***Siver Lakes Productions, Inc***. to record/film/produce at least eight training videos - **($8,000)**;

(1day) Fee for production/studio time **$3,200.00** (10 hours x $320.00)

(4 days) Post production days to produce, edit/mix sound, and editing of final product **$4,800.00** ($150.00 x 8 hours x 4 days)

Design and print manuals to accompany training modules and support/sustain staff utilization.

2) CSA Staff will participate in ***Reflective Supervison*** training **($2,000.00).** *(The regular and collaborative reflection between a service provider (clinical or other) and supervisor that builds on the supervisee's use of her thoughts, feelings, and values within a service encounter). This is an evidence-based model for supervison. A total of 6 FTEs at the CSA will be trained. The requested funding will purchase 10-hours of the trainer's time at a rate of* **$200.00 per hour**.

Note: The additional cost ($1,000.00 or 5 hrs) of the Refelctive Supervision training will be paid by the CSA.

Retention Expenses

Description of Expense	Cost

Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Job Posting & Advertising	$ 1,022.00
Total Recruitment Expenses	**$ 1,022.00**

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Recruitment of Outreach Coordinator: Postings on several career sites for 10 hour/week individual (ability to increase up to 20 hours) who is willing to be mobile and in the community. **($1,022.00)**
•Indeed Adverstising $500.00
•Google Adverstising $500.00
•Facebook Advertising $100.00

Note: The additonal cost $78 not covered by DSRIP funding will be paid by the CSA.

Training Expenses

Description of Expense	Cost
Total Training Expenses	**$ -**

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost

Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	**$ -**

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	**$ -**

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost

Total Retention Expenses	**$ -**

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Total Retention Expenses	**$ -**

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Total Retention Expenses	**$ -**

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 1 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	**$ -**

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Helpline at the Village: Pediatric Outreach and Partnership

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Outreach Coordinator	$ 15,080.00	0.5	5	$ 3,141.67
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0.5		$ 3,141.67
	Fringe rate	21.7%	Total Fringe	$ 681.74
			Total Program Staffing including Fringe	**$ 3,823.41**

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

An Outreach Coordinator will be hired to link with pediatric/physician offices, administer on-site social needs assessment, liaison with pediatric office staff, track, and follow up on referrals made.
Salary/benefits to hire new Outreach Coordinator to engage and be an onsite resource at primary pediatric practices during the 5-month PBP.

Other Operational Expenses

Description of Expense	Cost
Pediatric Forum for education/engagement	$ 1,250.00
Venue for Pediatric Forum	$ 500.00
Travel for Outreach Coordinator	$ 300.00
Resource DVD for Pediatric Offices	$ 1,253.49
Promotional Materials	$ 2,500.00
Total Other Operational Expenses	**$ 5,803.49**

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Pediatric Forum: *Host a forum for pediatricians to educate and engage them in the project.* Forum will inspire participation and expansion of the program. ***(Food for 50 participants x $25=$1,250.00)***
Venue: *Rent venue for the first forum* ***($500)***
Travel: *Estimated travel for the Outreach Coordinator, between practices, from January through May* ***($.50 per mile= 600 miles or 120 miles per month) ($300)***

Project 3 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	**$ -**

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Resource DVD: Produce and maintain Resource DVD for waiting rooms to educate/inform community members of CSA and other service opportunities. A DVD with resources that can be played at pediatric offices, as parents wait for their appointments. Pediatricians may also recommend its use in other settings. Silver Lakes Productions, Inc will complete voice overlay and DVD editing. **($150/hr X 8.36 hours= $1,253.49**)

Promotional Materials: **$2,500.00**

Social Determinants of Needs Assessment sheets **$100.00**: Screening tool utilized by PCP staff to assess the basic referral needs of their patients. This tool consists of 5 questions around housing, safety, mental health, financial, and food/clothing. 400

Business Cards **$200.00** : Outreach Coordinator will have professionally printed business cards to utilize with Pediatric Practices and families. 300

Posters **$300.00**: Visuals will be developed and printed on large corrugated boards and posted in each Pediatric Practice 500

Flyers **$200.00**: Informational flyers will be developed and placed in Pediatric Practice waiting areas 750

Giveaways: Will be purchased for marketing purposes in Pediatric Practices. These items will be for office staff and practitioners. These items will include: 250

- Pens- **$500.00** 200
- T-shirts- **$750.00**
- Note Pads- **$250.00**
- Hand Sanitizers- **$200.00**

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate: **11.50%**

Provide a brief description of how the Indirect Cost/Administrative Overhead rate was determined:

BAMSI calculated administrative rate :11.5 % on $76,187 operational budget =$8,761.00
For a Total Budget $84,948.00

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS May 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 5/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
Project 3	Wraparound Strength Based Electronic Record	Foster Integration with ACOs/MCOs, Community Partners and primary care providers by implementing an electronic record that assures interoperability and acccountability reporting	01/08/18	12/31/18	**Technology**	Development Adaptation of EHR and/or Care Management System	Meet with IT team to develop an implementation schedule including kick off meeting and training timeline by 3/1/18	Kick off meeting held, timeline in place and preproduction sandbox available						
		Strengthen fidelity to Wraparound processess with an electronic record designed with fidelity features and a patient portal	01/08/18	12/31/19	**Technology**	Development Adaptation of EHR and/or Care Management System	Convene parnter group with eHana to identify enhancements for the Comprehensive Assessment and Care Plan document by 5/31/18	Completed strength based Comp Assessment and Care Plan document in format for preproduction sandbox						
		Purchase 20 Surface Pros for CSA staff to remotely access the electronic record	01/02/18	05/31/18	**Technology**	Technology for Service Delivery	Purchase 20 Serface Pros, set up, and available for use by 5/31/18	Onsite and assigned to staff for use						
					Technology	Other Technology Expenses								
Project 1	Online Video Training	Produce 10 Vdeos for Tier 1 and Tier2 and Coaching Certification	01/15/18	12/01/18	**Workforce Development**	Retention Expenses	Production of 4 videos in partnership with Massasoit Community College, Silver Lake Productions and Bay State Community Services by 2/1/18	4 Videos completed and in use for training with staff						
		Train staff in Reflective Supervision (PBP) and Year 1 and send to Vandenberg training (Years 2-5)	01/01/18	12/31/22	**Workforce Development**	Training Expenses	CSA staff and supervisors will receive Reflectve Supervision training 5/31/18.	Completed training and implementation by supervisors and staff during supervision and updated CSA supervision policy.						
					Workforce Development	Retention Expenses								
Project 2	Helpline at the Village: Pediatric Outreach and Partnership	Collaborate with a minimum of three pediatric practices to provide an onsite resource for outreach, education and service navigation	06/01/18	12/31/21	**Operational Infrastructure**	Operational Staffing including fringe	Advertise & recruit Outreach Coordinator beginning 1/2/18	Hire Outreach Coordinator by 5/31/18						
		Develop and update, as needed, a DVD to educate families on community resources for viewing in waiting rooms	04/01/18	05/31/18	**Operational Infrastructure**	Other Operational Expenses	Conduct content research and design DVD format 4/30/18	Completed DVD in use at one pediatric site by 5/31/18						
		Host 2 community forums and educate local pediatrcians on CSA services	03/01/18	12/31/18	**Operational Infrastructure**	Other Operational Expenses	Convene Planning Team, identify invitation list of pediatric practices, and issue press release	Conduct first forum by 5/1/18 and second forum by 11/15/18						
					Operational Infrastructure									

REQUEST FOR RESPONSES: INFRASTRUCTURE AND CAPACITY BUILDING FUNDING FOR COMMUNITY SERVICES AGENCIES

SECTION 6.2: EXECUTIVE SUMMARY

BAMSI operated the Brockton Area Community Service Agency (CSA) since 2009 and has worked diligently on program enhancements and development. In accessing current needs and gaps, the CSA identified three primary projects for its Development Plan over the next 5 years: address recruitment and retention, increase ICC Engaged Members census, and enhance secure electronic communication capability. The three projects for our Development Plan are:

Project 1: **Workforce Development:** Training Enhancement, Coaching and Online Video Library.
Project 2: **Operational Infrastructure/Systems Change:** Increased access to care coordination and care management for ICC Engaged Members and Collaboration and Coordination with pediatric and other physical and behavioral health care providers across the care continuum.
Project 3 **Technology:** Build on current technology efforts to ensure timely and safe exchange of electronic information/data. Purchase mobile devices and utilize eHana HISP and Mass HIway.

A. BIDDER'S CURRENT PERFORMANCE ON ITS DEVELOPMENT PLAN:

WORKFORCE DEVELOPMENT: The Brockton Area CSA offers extensive training to staff during their tenure. Training is generally in a formal, class setting or one-to-one with supervisors or state-certified Wraparound Coaches. This process is time-consuming, costly and utilizes many resources. BAMSI CSA has designed a 5-year Development Plan that includes coordination of time, effort and resources with another CSA provider in the Southeast area. This plan will allow staff independent, diverse, multiple and role-specific skill building opportunities that is sustainable.

OPERATIONAL INFRASTRUCTURE/SYSTEMS CHANGE: EOHHS projected almost 8,000 children/youth eligible for Community Partner services in Southeast Massachusetts. BAMSI CSA has served approximately 200 unduplicated children/youth each year, since inception. In light of the EOHHS initial projections, the Brockton Area CSA needs to do more to reach eligible youth/families. Some of the efforts, to date, to increase census includes:

- BAMSI has an active and robust Local Systems of Care Committee that collaborate, network, educate and share resources for children/youth and to identify service gaps. The CSA facilitates these meetings, with over 50 members representing local schools, mobile crisis, police departments, state agencies, colleges, MCEs, faith-based organizations, parent professional organizations and medical/behavioral health providers. This forum has resulted in referrals to and from ICC and Family Partnership only services.
- The CSA has a coordinated outreach effort that has included program presentations to hospitals, CBATs, DCF, DMH, North River Health Initiatives and Social Service Agencies. Presentations have resulted in some community awareness and referrals.
- A recent partnership with Village Pediatrics of Brockton to conduct social needs assessments, information and referral, access to basic needs and resources and on-site consultation with parents. This outreach has resulted in increased referrals to BAMSI CBHI services, including ICC and Family Partnership only.

Although these efforts have been fruitful it is clear, based on "the average number of ICC-Engaged Members per month (Brockton CSA) served between March 1, 2016 and February 1, 2017 (Appendix D of RFR), that additional work must be done to reach and increase the number of children/youth eligible who benefit from CSA services in the Greater Brockton Area.

TECHNOLOGY: BAMSI uses eHana as its electronic health record (eHR) and has successfully implemented this system in its outpatient network, across 9 Day Habilitation programs and the Adult Day Treatment Center. The Brockton CSA is scheduled for implementation of eHana in late fall/winter. With the availability of DSRIP funds, the 6 CSAs using the eHana eHR have initiated discussion with them for the design of customized features that more appropriately reflects Wraparound strength-based language, supports Mass HIway integration, and easily tracks quality and accountability measures consistent with those outlined by EOHHS.
BAMSI is currently participating in a Connected Communities Grant with Signature Health, Good Samaritan Hospital, Brockton Neighborhood Health Center and High Point Inc. to transmit electronic referrals via the Mass HIway and will continue use this mode of transmission if needed to electronically transmit data/information beyond the eHana system. BAMSI also participated in the Steward Healthcare Capacity and Infrastructure Building pilot for Accountable Care Organizations. BAMSI is well positioned and ready to fully implement its eHR at the CSA and is excited to work with eHana and CSA partners to strengthen fidelity to the Wraparound process and improve care management.

B. EXAMPLES OF STRENGTHS AND NEEDS: BAMSI has 42 years of experience serving culturally diverse youth and families with SED and/or emotional distress, trauma, or complex MH/BH challenges. BAMSI's services include adult day and residential programs, outpatient mental health services, EI, WIC, therapeutic day supports, family stabilization, CBHI services, Helpline, an afterschool program and in-school consultation. BAMSI has many longstanding community linkages/affiliations and nearly 2,000 employees.
The 3 main strengths of the Brockton Area CSA are:

1. Diverse staff (language and culture), a nationally -certified Wraparound coach and 50% Family Partners have Bachelor level degrees.
2. Robust Local System of Care team, strong connection with Brockton Public schools and co-located with the Helpline resource.
3. Each staff has I-Phone, desk-top computer and is generally technologically astute.

The 3 main identified needs of the Brockton CSA are:

1. Improved recruitment and retention strategies.
2. Improved marketing and outreach efforts that support timely access to services and increased census.
3. Implementation of a secure and strength-based electronic health record.

C. PLANS FOR IMPROVING TIMELY ACCESS TO ICC SERVICES: The 1st project will work to recruit, consistently train and retain qualified staff, thus improving/increasing timely access for ICC-Engaged members and their families. The 2nd project provides information and referral linkages onsite at pediatric practices where eligible children/youth/families gather and referrals can be made in a timelier manner, through communication bridging. The 3rd project will allow CSA staff to respond more quickly to referrals at the location most convenient for

youth/families and more quickly document information electronically (keeping to Wraparound Principles) and to safely yet quickly communicate information to other involved providers and natural supports.

D. PLANS FOR IMPROVING CARE COORDINATION, CARE PLANNING, AND CARE MANAGEMENT FOR ICC ENGAGED MEMBERS: Each of the 3 projects contribute to the improvement of care coordination, care planning, and care management for ICC Engaged members.

- **Workforce Development Project**: Provide structured and convenient Tier 1 and Tier 2 coaching training and Reflective Supervision training to enhance staff skills.
- **Operational Infrastructure/Systems Change Project**: Onsite bridging of communication with pediatric primary care providers will support increased care coordination, care planning and care management amongst providers and to Engaged Members.
- **Technology Project**: Staff will have continuous access to records. Families will be able to easily review and approve/sign plans, and information will be electronically exchanged with all team members, including ACOs and MCOs.

E. PLANS TO IMPROVE PERFORMANCE ON QUALITY SCORES AND DEVELOPMENT PLAN GOALS:

BAMSI will work with eHANA to ensure that data tracking, dash-boarding, and essential reporting features are included to capture ongoing performance and quality measures. This work may include business process analysis, eHR modifications, reporting enhancements, and data export integrations, for reporting quality measures in a structure format. These features will include:

- Claims/Encounter Only Measures: BAMSI will work with eHana to automate the import/collection of quality data BAMSI will work with EOHHS/ACOs/MCOs, other health care providers, and community stakeholders to build data interchanges to support real-time quality analytics.
- Chart Review Measures. BAMSI will use existing tools and technologies, such as auditor logins, encrypted PDF exports, and data analytics to support submission of the quality reporting to EOHHS/ACOs/MCOs and to provide access to additional data or information necessary to audit or validate submitted data.
- Engaged Enrollee Experience Survey. BAMSI will support EOHHS in execution of the Engaged Enrollee Experience Survey.

F. PLANS FOR IMPROVING COORDINATION WITH PEDIATRIC PRIMARY CARE AND OTHER PHYSICAL AND BEHAVIORAL HEALTH CARE PROVIDERS ACROSS THE CARE CONTINUUM FOR YOUTH:

Lessons learned from the "Helpline at the Village" project will steer enhancements, to this partnership, and replicated in the future with other pediatric primary care providers. Some negotiated developments with Village Pediatrics include: advanced data tracking systems, two-way access to demographics, resource-based DVD for waiting area and follow-up outreach to families served.

SECTION 6.3 - POPULATIONS SERVED AND COMMUNITY ENGAGEMENT

A. MEMBER POPULATIONS, COMMUNITIES SERVED, AND EFFORTS TO PROMOTE HEALTH AND WELLBEING:

BAMSI operates the Brockton Area CSA serving Brockton and the 7 surrounding towns of Avon, Bridgewater, East Bridgewater, West Bridgewater, Easton, Holbrook and Stoughton. BAMSI's Child, Family and Community Services network includes Wraparound Family Services which extends throughout the Southeast region including programs in Taunton/Attleboro, Plymouth, Quincy, New Bedford/Fall

River and Cape Cod. BAMSI serves approximately 25,000 people a year, 70% of whom are served in the Greater Brockton area. Of those, 42% are children/youth.

The Brockton Area CSA demographics from a 2017 study indicate:

CSA Population / Languages Spoken/Presenting Primary Mental Health Challenges: July 1st 2016 – June 30th 2017

LANGUAGE	PRESENTING PRIMARY MENTAL HEALTH CHALLENGES
English = 189 Spanish = 18 Haitian Creole = 10 Cape Verdean Creole= 11	Bi-polar Disorder (1), Mood Disorder (1), Schizoaffective Disorders (2), Major Depressive Disorder (10), Major Depressive Reoccurring Disorder (8), Dysthymic Disorder (6), Generalized Anxiety Disorder (11), Oppositional Defiant Disorder (34), Intermittent Explosive Disorder (1), Pervasive Developmental Disorder (1), Attention Deficit Disorder (78), Reactive Attachment Disorder (3), Mental Disorder (NOS) (72)
TOTAL SERVED = 228	

CSA Breakdown by Self-Reported Ethnicity of Persons Served: July 1st 2016 – June 30th 2017

ETHNICITY	#	ETHNICITY	#	ETHNICITY	#		#		#
Caucasian	88	Bi-racial	20	Black	1	Cape Verdean	11	Haitian	10
African-American	27	White/Black	1	Black/Hispanic	1	Asian	2	Puerto Rican	1
Hispanic	16	White/Hispanic	1	American/Indian	4	Latino	1	Unreported	40

CSA Breakout by Age Range and Gender: July 1st 2016 – June 30th 2017

AGE RANGE	#	AGE RANGE	#	AGE RANGE	#		#	GENDER	
4 – 6 years	24	7 – 12 years	89	13 – 17 years	95	18 – 20 years	20	Female = 84	Male = 144

In service to a community with a number of risk indicators it is evident that efforts to promote health and wellbeing are crucial in strengthening the community and supporting residents, particularly children/youth. BAMSI has provided public health services including Brockton Early Intervention, nutrition services at its two WIC programs and HIV Case Management, Outreach, Prevention and Education. In the 1990's BAMSI was instrumental in establishing the Brockton Neighborhood Health Center (BNHC) and maintains a seat on the BNHC Board of Directors and collaborates on many projects including the Massachusetts eHealth Institute Connected Communities grant. BAMSI also partnered with Steward Healthcare in 2016 on 3 infrastructure and capacity building ACO pilot projects related to improved care transitions. BAMSI operates 120 residential and day programs across the state for those with disabilities and complex medical needs, employs over 300 nurses, maintains a vast library of medical policies/protocols, and has a Medical Risk Committee that meets bi-monthly to evaluate risk and improve outcomes for those served.

The Brockton Area CSA promotes the health and wellbeing of engaged members by completing Comprehensive Home Based Assessments that explores all life domains, including health and recreation. The CSA utilizes the support of the BAMSI Helpline to research and access services and support needs identified by enrolled members and their teams. The CSA ensures community involvement of members through

schools, YMCA, Boys and Girls Club, churches, community leagues, well-visits, social events, community walks, and annual resource fairs. The CSA works collaboratively with the Helpline to complete Service Needs Assessments with families and provide information, referral and consultations to bridge gaps, deter evictions, develop payment plans, access utility resources, negotiate utility discounts and obtain basic goods such as diapers, formula, food, clothing, rent assistance, etc. The CSA staff accompanies youth and parents to medical and behavioral appointments, as requested and indicated, and support families with medical follow-through and health insurance documentation. The CSA maintains engagement with members through various means of outreach, which includes face-to-face, telephone, meetings, emails, texts messages, groups, specials events and parent workshops. Team members of enrolled youth and families support ongoing engagement. BAMSI will build on the experience and expertise in serving diverse populations and meeting individual healthcare and public health needs of Engaged Members.

B. **RELATIONSHIPS WITHIN THE COMMUNITY LEVERAGED TO IMPROVE ICC SERVICES**

BAMSI has developed and maintains several linkages and affiliations with community organizations that has and/or will be leveraged to improve ICC services. Over 40 years BAMSI has developed an extensive network of affiliations and partnerships, including:

SERVICE TYPE	ORGANIZATIONS
Schools and Colleges	Public Schools (8 towns served), Massasoit Community College, Bridgewater State University, The Goddard School, North River Collaborative, South Shore Collaborative, South Eastern Regional, Recovery High School, High Roads of Mass.
Pediatric Clinics	Village Pediatrics, Brockton Neighborhood Health Center, Bulotsky & Associates, Brockton Pediatrics,
Child Care Providers	Brockton Day Nursery, PACE, Healthy Beginnings, YMCA Child Care, Little Discoveries
Family Organizations	WIC Brockton, The Family Center, Family Support Center, Adoptions Journey, Adoptions Crossroads, PIN,
Community Based Organizations	Brockton Neighborhood Health Center, Safe Corners, Brockton Police Department, Catholic Charities, Highpoint, The Castle, E.B. Hope, C.O.P.E, BAMSI Helpline, United Way, Brockton ARC, Recovery Learning Center, Health Imperatives, JRI, MAY Institute,
Youth Service Organizations	Stoughton Youth Commission, BrAGLY, Gandara, Old Colony YMCA, Boys & Girls Club, Home Based Team, Youth Villages
Advocacy Groups	Young Adult Group, Parent Information Network, Parent Professional Advocacy League, Citizens for Citizens,
Behavioral Health Providers	Bay Coast Behavioral, South Bay Community Health, Northeast Family Services, Whitman Counseling Center, Family and Community Resources, New Hope Counseling, Manet Community Health Center, Bay Coast Human Services, Bay State,
Child Serving State Agencies	Plymouth Child Advocacy Center, DCF, DDS, DEEC, DESE, DMH, DPH,
Courts	Brockton Juvenile Court, Plymouth County District Attorney's Office, Wareham Court,
Hospitals/CBATS/ESP/MCI	Caritas Good Samaritan Medical Center, Signature Healthcare – Brockton Hospital, Carney hospital, Pembroke Hospital, Walker, McLean's, Franciscans, NEMC, Boston Children's, Mass. General, Brockton Multi-Service Center, CCBC,
Housing/Shelter providers	Brockton Housing Authority, Father Bills & Mainspring, DHCD, Housing Solutions,
Social Service Organizations	Salvation Army Brockton, Self Help Inc., Old Colony Elderly Services, Inc., National Grid, Catholic Charities, Toys for Tots, Charity Guild, DJ Henry Foundation, My Brother's Keeper, Cradles 2 Crayons, Friends of the Homeless,
Recreational/Athletic Associations	YMCA, Boys and Girls Club, MATA Karate Studio,
Early Intervention Services	BAMSI Early intervention, South Bay Early Intervention,
Other	DTA, Harbor One Bank, Language line, Career Works, Make A Difference in Children, The Learning Center for the Deaf, READS Collaborative, Cape Verdean Association, Silver Lake Productions,

In addition, BAMSI participates on 22 community councils, advisory boards and organization Boards of Directors.

Improvement in ICC services is achieved by outreaching to these organizations and leveraging relationships for participation in Local Systems of Care Committee, collaboratively identifying service gaps and brainstorming solutions, providing crisis intervention and safety planning, accessing and supporting services, facilitating service navigation, and sharing in collaborative learning opportunities. BAMSI also leverages its longstanding relationship with DMH Area and Site offices through contract meetings, collaborative intakes, crisis management/mobile crisis unit and shared events, which further enhances care planning, fosters team-based collaboration and outcome-based strategies and effective clinical interventions for those served. BAMSI is committed to current affiliations and to expanding community relationships/partnerships as illustrated by the proposed Operational Infrastructure project aimed at improving connection and integration with pediatric practices, modeled after an already successful BAMSI community partnership with Village Pediatrics. BAMSI is also the provider of several child/youth programs including DPH funded Early Childhood Intervention and WIC services; DMH funded afterschool and family stabilization services, the Parent Information Network which offers parent and education advocacy and family support services; and DDS funded ICC, family support, and services for medically complex children/youth. BAMSI's Child Family and Community Services is a collaborative network that maximizes resources, shares expertise and best practices to support and promote improved ICC.

C. How Current and Planned Partnerships Align with Proposed Projects:

BAMSI proposes three projects, all of which align with current and planned partnerships. The first, Workforce Development Project, is a collaborative effort designed in conjunction with the CSA/ICC provider organizations in the Southeast region. Since its inception BAMSI has worked collaboratively with one other CSA partner teams on a number of initiatives. The second project focuses on systems change in the domain of Operational Infrastructure. Currently BAMSI partners with Village Pediatrics to conduct social needs assessments with individuals served by the Village Pediatrics practice. Given the success of this endeavor, BAMSI proposes to partner with other pediatric practices to extend this service into other pediatric offices, thereby strengthening relationships, community and breaking down barriers to access for ICC services for those who might benefit from ICC. In addition referrals will be made to other community organizations with whom BAMSI already partners. The third project in the area Technology is also a collaborative effort with other CSA/ICC providers using the eHana electronic record to build more strength based language/documents into the existing system.

SECTION 6.4 PROPOSED PROJECTS AND INVESTMENT PLAN

A. PROJECT DESCRIPTION

	WORKFORCE DEVELOPMENT	OPERATIONAL INFRASTRUCTURE	TECHNOLOGY
1. Name/Title of Project	**Online Video Training Library**	**"Helpline at the Village" - Pediatric Outreach and Partnership**	**Wraparound Strength-Based Electronic Record**
2. Goals advanced & Plans to Address Goal through the project	**Goal:** Strengthen fidelity to Wraparound processes, including care planning, care management, and care coordination for ICC Engaged Members and their families. **Plans to Achieve Goal:** Create comprehensive and sustainable employee training to improve recruitment/retention, access, engagement, and optimal care coordination. Work with Southeast Area CSA to develop a video training library for Tier 1 and Tier 2 Wraparound Coaching and Certification to facilitate improved outcomes for ICC Engaged Members. Each CSA will contribute to content and work with videographer and Massasoit Community College to create a learning segment. Format and approach has been discussed, topics researched, subject matter experts identified, experienced production team engaged.	**Goal:** Improve timely access to ICC services for children eligible to receive ICC and their families *Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members* **Plans to Achieve Goal:** Based on positive outcomes of the "Helpline at the Village" pilot, BAMSI will enhance this partnership through use of advanced data tracking systems, two-way access to demographics, resource-based DVD for Village Pediatrics waiting area and other locations and ensure follow-up outreach to families served. Replicating this pilot and lessons learned from the Village Pediatrics experience, BAMSI will outreach to other pediatric practices and expand this project throughout the Brockton CSA Area.	**Goals:** *Improve timely access to ICC services for children eligible to receive ICC and their families* **and** Strengthen fidelity to Wraparound processes, including care planning, care management, and care coordination for ICC Engaged Members and their families. **Plans to Achieve Goal:** BAMSI will work collaboratively with other CSAs and eHana to design customized Wraparound fidelity features, implement its eHR assuring interoperability with Behavioral Health (BH) and Long Term Services and Supports (LTSS) Community Partners, ACOs/MCOs, and assure quality and accountability measure reporting
	WORKFORCE DEVELOPMENT	**OPERATIONAL INFRASTRUCTURE**	**TECHNOLOGY**
3. Scope (duration, methods, activities to accomplish goals)	Identify trainers for each topic. Secure permissions and licenses. Contract with videographer.	Identify (in collaboration with Village Pediatrics) pertinent data to be tracked. Identify an advanced data tracking system.	Work with eHana and other CSAs to design/enhance current eHR with features and functionality to support integrated and

	Tape topic sessions with input from State certified Wrap coaches. Develop Self-test manuals for each topic. Convene a test group to try materials. Make required edits. Post videos online for easy access to all CSA staff. ***Duration*:** Four initial videos will be available on-line by May 2018, with four additional segments added by late 2018 with full library completed in Year 2. 2, minimally supported Years 3 - 5 to print materials. Reflective Supervision training will commence in 1/1/18 thru 5 years of project	Explore two-way access to demographics. Develop a resource-based DVD with BAMSI's Community Relations. Design, test and implement plan for follow-up outreach to families served. Obtain testimonials from staff at Village Pediatrics: benefits and challenges. Also obtain testimonials from persons served at Village Pediatrics. Develop outreach/marketing strategy to engage other area pediatricians. Host community pediatric forums. Recruit and train volunteers. ***Duration:*** 5 years – Expand role at Village Pediatrics and hire Outreach Coordinator during Preparation Budget period. Host 2 forums (Preparation budget and Year 2) and expand to 3 additional practices by end of Year 5.	collaborative models of care: ▪ Implement Wraparound Strengths Based Language. ▪ Patient Portal. ▪ Standardized and Secure Data Exchange Formats (transmission via HISP to Mass HIway & other partners). ▪ Quality and Accountability Measure Reporting. Develop Implementation Plan including testing and training of staff. Continue to refine. ***Duration:*** 5 years - Design & test during Preparation Budget Period, Implement eHR by April 2018. Continue implementation of enhancements Year 1 & 2. Refine & support Years 3-5.
4. Proposed Deliverables	▪ Wraparound Fidelity best-practice and evidence-based training videos online and easily accessible. ▪ Continuous learning and professional growth opportunities. ▪ Staff retention through increased opportunities to grow and obtain free CEUs towards licensure. ▪ Enhanced staff skills in Wraparound fidelity (including care coordination, care management and care planning).	▪ Resource DVD developed and utilized at Village Pediatrics & beyond. ▪ Enhanced tracking system. ▪ At least 6 meetings with pediatricians to promote the project and collect survey responses based on their individual practice needs. ▪ At least 4 pediatric practices engaged in the project at end of 5 years.	The CSA eHana eHR will include: ▪ Strength-based forms and language, in particular the Assessment and Care Plan. ▪ A "golden thread" throughout the record, from assessment through care plan, progress monitoring and transition planning. ▪ Secure exchange of data with EOHHS; ACOs/MCOs; other primary providers. ▪ Report on claims/encounter measures. ▪ Chart Reviews. ▪ Engaged Member Satisfaction Survey. ▪ CANS Reporting.
	WORKFORCE DEVELOPMENT	**OPERATIONAL INFRASTRUCTURE**	**TECHNOLOGY**
5. Specific use of DSRIP funding & how goal supported	Fee for videographer and Massasoit Community College to produce training videos. Design and print manuals to accompany	Salary/benefits to hire new Outreach Coordinator to engage and be an onsite resource at primary pediatric practices. Develop promotional materials to	Fee for eHana programming & development of electronic enhancements consistent with Wraparound language and EOHHS goal of secured mechanisms to

	training modules and support/sustain staff utilization. Fee to use licensed/copyrighted materials to ensure evidence based best practices presented. Fee for set up of web-based hosting to assure user friendly on-line access.	distribute at pediatrician offices. Produce Resource DVD for waiting rooms to educate/inform community members of CSA and other services. Host pediatric education/engagement events to inspire participation and expansion of the program.	support data exchange. Fee for eHR implementation including licensure and IT support. Cost to purchase and set up 11 Surface Pros for CSA staff used in care plan meetings, including video conferencing and data exchange with ACOs/MCOs and others as needed.
6. Existing Internal Resources to be utilized to implement project	Corporate Relations Team to coordinate with videographer and develop training manual. Professional Development & Training Department to promote and track training Project Management - research, planning, coordination & oversight of the project. BAMSI Training Space & IT staff to support production. BAMSI Website to access training library Wrap ICC Coach to review all material and ensure fidelity to the model.	Helpline Director to enhance Village partnership and train newly hired Outreach Coordinator. Supervisory oversight of project. Information & Referral database utilized as resource for all pediatric practices. Social Needs Assessment Tool duplicated and used to assess need and connect with community members to resources, including referral to CSA. Employee Travel Expense. Office Supplies.	IT Project Management & Oversight. Leadership planning to assure successful implementation and training of staff. Development of training materials and manual as resource to support and sustain utilization. IT staff time to test and train CSA staff.
7. Allocation of Funds across CSA and BAMSI	Funds will be allocated solely to the CSA.	Funds will be allocated to the CSA. A portion of funds will be accessed by Helpline staff to support the Village effort and to train/supervise the new Outreach Coordinator.	Funds will be allocated to the CSA. The CSA will be charged licensing, implementation and set-up fees by BAMSI IT Department.
8. Evaluation, measurement or performance management strategies to demonstrate effectiveness	▪ More timely completion of coaching certification for CSA staff. Comparative data baseline: post implementation. Track improvements as library expands and incentives offered by BP5. ***Staff responsible:*** *PD&T with Sr. Program Director* ▪ Improved clinical competence for ICC staff. Pre & Post- test comparative data Match Bachelors to Masters/licensed. Self-identified scoring 75% or higher improvement by BP3. ***Staff***	▪ 10% increase in census year over year. Data: DSRIP census of 77 at baseline: DSRIP census allocation Years over years 1-5 will increase by 10% each year. ***Person responsible:*** *Sr. Director of Operations Child, Family & Community Services* ▪ Improved collaboration with primary care providers (physical & behavioral health) Year over Year as indicated by Care Plan attendance sheets/absence forms by BP3. Data generated from	▪ The eHana electronic record (eHR) will be implemented by April 1, 2018 BP2. ***Person responsible:*** *Vice President IT* ▪ All CSA staff will utilize the eHR for care planning and data collection on quality measures by the end of BP2. Data: eHR reporting. ***Persons Responsible:*** *Vice President of Child, Family & Community Services in conjunction with Sr. Director of Operations & Sr. Program Director*

	responsible: *PD&T (online test) and Sr. Program Director (analytics).* ▪ Improved WIFI - EZ and Toms 2.0 scores (Wraparound Fidelity). ▪ *Specifically, we would improve our WIFI-EZ scores in Natural Supports and Family Voice and Choice. Our scores will improve by 5% points in each area.* ▪ *In the TOMS 2.0, we would also improve in Natural supports and Family Voice and Choice by 5% percentage points in each area.* ▪ We will do this by reviewing baseline data to post training implementation by BP4. ***Staff responsible:*** *Sr. Program Director* • Improved retention of ICC staff. Comparative data prior 12 months to 1 year post training by BP2. ***Staff responsible:*** *Director Talent Acquisition and Retention*	eHR. ***Person responsible:*** *Sr. Program Director* ▪ Expansion of Village Partnership to a minimum of 3 additional pediatric practices by BP5. ***Persons responsible****: Vice President of Child, Family & Community Services in conjunction with Helpline Program Director and Outreach Coordinator* ▪ 2 Pediatric/Primary Care Forums will be held by the end of BP2. *Person Responsible: Sr. Program Director in conjunction with Outreach Coordinator*	▪ Increased electronic bidirectional communication between CSA and other care providers by the end of BP2. Year over year data analysis Year 1 forward. ***Person Responsible****: Sr. Program Director* ▪ Evidence of 'golden thread' in chart audits. Comparative data beginning & end BP2: each subsequent year. ***Person responsible:*** *eHana with Vice Presidents IT & Child Family Community Services* • Timely reporting on quality and accountability measures to EOHHS/ACOs/MCOs. Measure: continued DSRIP funding through BP5. ***Person responsible:*** *Sr. Director of Operations CF&CS*

Performance Management will be monitored by the BAMSI Quality Improvement Department. The CBHI Committee will review findings and determine any course corrections.

B. Project Team Description

1. See Organizational Chart and Job Descriptions Attached

2. – 4. Project Staff – Current and New, Qualifications and Responsibilities, including Project Management

PROJECT 1:
Online Video Library

NAME & TITLE	QUALIFICATIONS	PROJECT RESPONSIBILITIES	NEWLY HIRED/ENGAGED STAFF	QUALIFICATIONS AND RESPONSIBILITIES FOR PROJECT
Aisha Bonny Sr. Director of Operations Child, Family and Community Services	Project management, collaborative skills and an ability to facilitate teamwork. Skilled in mediation and outcome-based strategies. Experience in training and curriculum development.	**Project Manager:** Oversee project in coordination with CSA Providers to assure curriculum development and consensus, work with team to schedule and ensure conformance with timelines and budget.	Lynn Scornavaca Owner & Founder Silver Lake Productions Videographer Narrator	*Qualifications:* Over 20 years of experience in video production, produced 25 plus videos for BAMSI events. Maintains archives of photos and videos for BAMSI *Responsibilities:* Record and produce training modules
Kathy Anderson Director Brockton CSA	Certified and experienced Wrap Coach. Independently licensed Social Worker. Experience training staff in wraparound fidelity.	Develop content in coordination with other CSA Directors, develop materials for training manual.		
Barbara Duffy Vice President Community Relations	Technological skill and experience monitoring quality of productions and conformity to requirements.	Coordinate with Videographer and Website Host to upload trainings to website.		
Sonia D'Alarcao Sr. Program Director Professional Development and Training Dr. Lizzie McEnany, Psych. D. Licensened Psychologist, HSP	Experience developing curriculum materials, training trainers, coordinating and tracking required staff training for completion. Reflective Supervision Trainer	Produce training manual, maintain training database and track training completion Conduct Reflective Supervision training to CSA leadership		

PROJECT 2:
"Helpline at the Village"
– Pediatric Outreach and Partnership

NAME & TITLE	QUALIFICATIONS	PROJECT RESPONSIBILITIES	NEWLY HIRED/ENGAGED STAFF	QUALIFICATIONS AND RESPONSIBILITIES FOR PROJECT
Beverly Williams Vice President Child, Family and Community Services	Licensed Marriage and Family Clinician. Masters in management with concentration in Organizational Development. Experience in community bridging and network expansion and enhancement. Event planning, budgeting and budgeting skills.	**Project Manager:** Oversee project in coordination with Village Pediatrics and others, ensure all elements of the project implemented, including well planned and coordinated pediatric events, work with stakeholders to complete DVD, ensure conformance with timelines and budget.	Lynn Scornavaca Owner & Founder Silver Lake Productions Videographer Narrator Massasoit Community College Studio and production team	*Qualifications:* __ years of experience in video production, produced 25 plus videos for BAMSI events. Maintains archives of photos and videos for BAMSI *Responsibilities:* Produce DVD
Faith Frazier Director Helpline Information & Referral	30 years of experience in information and referral service and resource search. Strong community networking and advocacy. Ability to negotiate on behalf of others. Trainer of BAMSI's New Employee Orientation.	Expand Village Pediatric experience, ensure use of DVD and materials, train and supervise Outreach Coordinator, support pediatric events and engagement	Outreach Coordinator (To be Hired)	Administer Social Service Needs cards. Explore resources and services required. Provide information and referral services and/or consultation.
Barbara Duffy Vice President Community Relations	Technological skill and experience monitoring quality of productions and conformity to requirements. Develops and designs promotional materials, and promotes events and services.	Coordinate with Videographer, work with team to develop promotional materials and advertise events		

NAME & TITLE	QUALIFICATIONS	PROJECT RESPONSIBILITIES	NEWLY HIRED/ENGAGED	QUALIFICATIONS AND RESPONSIBILITIES FOR

			STAFF	PROJECT
Margot Carleton Vice President Information Technology Services	Attained a degree in Management Systems and a minor in Computer Science. Skilled in the selection and roll out of Electronic Healthcare Record solution.	**Technology Project Manager:** Oversee technology elements of the project in coordination with eHana, BAMSI, and CSA providers, ensure testing, security assignments, implementation and staff engagement in conformance with timeline and budget. Order surface pros and assure set up	eHana Programming and Development Team	Demonstrated and successful experience with implementation, deployment, and support of electronic health record and other complex technologies. Worked with BAMSI for 4 years to implement eHR in outpatient, day habilitation, and day treatment. Work with team to design enhanced MAP, ePrescribe and Meaningful Use features
Beverly Williams Vice President Child, Family and Community Services	Organizational Development specialist with expertise in change facilitation, time management and budget monitoring.	**Operational Project Manager:** Oversee and manage operational aspects of the project in coordination with eHana and BAMSI IT, ensure engagement of staff, advise on direction and content security, etc. and ensure compliance to timeline and budget constraints.		
Aisha Bonny Sr. Director of Operations Child, Family and Community Services	Experience in Wrap fidelity, staff training and development and coordination of services and support.	Part of the implementation team giving input on content and structure, support staff in change process, test and train staff		
Kathy Anderson Sr. Program Director Brockton CSA	Certified and experienced Wrap Coach with extensive knowledge of Wraparound process and CBHI policies, procedures and expectations.	Work as part of the implementation team giving input on content and structure, supervise CSA staff in the process, support change process, and ensure thorough testing and training of staff for on time implementation. Purchase Surface Pros.		

5. Project Management: As indicated above, each project has a named Project Manager who will be responsible for oversight and coordination of the project from beginning to end. The Project Manager will coordinate team efforts and assure timelines are met and budget adhered to. For the Technology Project two Project

Managers are identified: one to manage technology and coordinate with eHana, and the other to assure operational input, testing and field implementation. This model has been successfully used on other technology projects at BAMSI, including implementation of the electronic record.

C. IMPLEMENTATION PLAN AND TIMELINE

TIME PERIODS	PROJECT 1 Online Video Library	PROJECT 2 Village Pediatrics – Pediatric Outreach and Partnership	PROJECT 3 Wraparound Strength-Based Electronic Record
PREPARATION BUDGET PERIOD			
December 2017	Hire and sign an agreement with the videographer and Massasoit Community College. Convene 2-3 telephone &/or in-person conferences with other CSA to continue planning of library and discuss content of first 2 videos. These meetings will be attended by BAMSI's VP of Corporate Relations. Develop MOU for Reflective Supervison training with Dr. Lizzie McEnany	Collaborate with Village Pediatrics and videographer on the design and content of Resource DVD for use at Village Pediatrics. Brainstorm needs of database system, in conjunction with Village Pediatrics. Begin recruitment of Outreach Coordinator.	Collaborate with eHana and CSA providers to develop strength-based language for the assessment, care plan and other documents. Develop the enhanced features for the electronic record. The Brockton CSA will implement the existent electronic health record with the IT team. Initiate team meetings to discuss expectations, progress and utilization of the enhanced software.
January 2018	Begin the production of the first 4 videos, with input from the CSAs and Wrap ICC coach. Identify any required licenses and content needed for accompanying manual. Research proprietary curriculum and make payments. Commence Reflective Supervison training with CSA Leadership/supervisors	Continue recruitment of Outreach Coordinator. Design and develop first draft of the Resource DVD for use at Village Pediatrics. Develop promotional materials. Begin planning and promotion of the first Pediatric forum. Secure venue. Explore enhanced database system.	Order 11 Surface Pros Conduct training with staff on the ehana electronic record system. Initiate team meetings to discuss expectations, progress and utilization of the enhanced software.
January/February 2018	CSAs will review first 4 Videos and provide feedback and additional suggestions.	Hire Outreach Coordinator. Distribute invitations to the Pediatric Forum. Provide personal outreach. Obtain feedback from Village	Set-up 11 Surface Pros and conduct training with staff on its utilization. Conduct training with staff on the ehana electronic record system.

	Continue Reflective Supervision training	Pediatrics on the drafted Resource DVD for use at Village Pediatrics. Test database systems.	Testing and refinement of electronic health record based on staff feedback and identified challenges. Develop security protocols. Initiate team meetings to discuss expectations, progress and utilization of the enhanced software.
February – March 2018	CSAs will refine first 4 videos provide feedback and additional suggestions for completion gathering input from staff and families.	Train the new Outreach Coordinator Finalize edits and produce the Resource DVD for use at Village Pediatrics. Select enhanced database system.	Testing and refinement of electronic health record based on staff feedback and identified challenges. Develop security protocols. Initiate team meetings to discuss expectations, progress and utilization of the enhanced software.
April – May 2018	Finalize and post the first 4 videos And complete 4 additional videos Complete Reflective Supervision training	Host the first Pediatric Luncheon Forum. Launch the Resource DVD at Village Pediatrics. Develop a promotional PowerPoint to demonstrate the benefits and successes experienced in the partnership with Village pediatrics.	Testing and refinement of electronic health record based on staff feedback and identified challenges. Develop security protocols. Electronic health record in full production by April 2018 Initiate team meetings to discuss expectations, progress and utilization of the enhanced software.
BUDGET PERIOD 1			
June 2018 – June 2018	Convene 2-3 telephone &/or in-person conferences with other CSA to continue planning of library and discuss content for additioanl videos	Outreach Coordinator to schedule meetings and/or presentations.	Launch full utilization of both the Brockton CSA and the strength-based electronic record.
July 2018 – September 2018	CSA will utilize videos for staff training and test accompanying manual	Engage one other Pediatric practice. Facilitate meetings with the new practice and Village Pediatrics to determine strengths, challenges and any gaps. Review tracking systems.	Continue utilization of electronic record, updating as needed. Test interoperability with ACOs, MCOs and other providers. Begin tracking quality and accountability measures.
October 2018 – December 2018	Continue utilization and plan production of remaining videos	Facilitate meetings with the new practice and Village Pediatrics to determine strengths, challenges and any gaps. Review tracking systems. Host second	Reporting on quality and accountability measures.

		Pediatric Luncheon	
BUDGET PERIOD 2			
January 2019 – March 2019	Convene 2-3 telephone &/or in-person conferences with other CSA to continue planning of library and discuss content	. Facilitate meetings with the new practice and Village Pediatrics to determine strengths, challenges and any gaps. Review tracking systems.	Continue utilization of the electronic record. Consultation with eHana for maintenance, updates and enhancements as needed. Continued collaboration with the CSAs on best-practices. Track data and report on outcomes as required. Refinement and consultation.
April 2019 – June 2019	Begin production of remaining videos	Outreach to Pediatricians to schedule meetings and/or presentations. Facilitate meetings with the new practice and Village Pediatrics to determine strengths, challenges and any gaps. Review tracking outcomes. Expand Outreach Coordinator hours to 20/week	
July 2019 – September 2019	Finalize and post videos 9 and 10. Continue utilization for new staff as hired and refreshers, if needed.	Facilitate meetings with the new practice and Village Pediatrics to determine strengths, challenges and any gaps. Review tracking systems and outcomes.	
October 2019 – December 2019	Review all videos for edits as needed, assure staff access, utilization and refinement. CSA will complete a staff survey on videos and manuals.	Engage one other Pediatric practice. Facilitate meetings with the 3 practices to determine strengths, challenges and any gaps. Review tracking systems.	
BUDGET PERIOD 3			
January 2020 – March 2020	Editing and maintenance of 10 online videos and manuals.	Facilitate meetings with the 3 practices to determine strengths, challenges and any gaps. Review tracking outcomes.	Continue utilization of the electronic record. Consultation with eHana for maintenance, updates and enhancements as needed. Continued collaboration with the CSAs on best-practices. Track data and report on outcomes as required.
April 2020 – June 2020		Outreach to Pediatricians to schedule meetings and/or presentations. Review tracking systems.	
July 2020 – September 2020		Facilitate meetings with the practices to determine strengths, challenges and any gaps. Review tracking systems.	
October 2020– December 2020		Facilitate meetings with the new practice and Village Pediatrics to determine strengths, challenges and any gaps. Review tracking systems.	

BUDGET PERIOD 4			
January 2021 – March 2021	Editing and maintenance of 10 online videos and manuals.	Facilitate meetings with the new practice and Village Pediatrics to determine strengths, challenges and any gaps. Review tracking systems. Outreach to Pediatricians.	Continue utilization of the electronic record. Consultation with eHana for maintenance, updates and enhancements as needed. Continued collaboration with the CSAs on best-practices. Track data and report on outcomes as required.
April 2021– June 2021		Facilitate meetings with the 3 practices to determine strengths, challenges and any gaps. Review tracking systems.	
July 2021 – September 2021		Facilitate meetings with the practices to determine strengths, challenges and any gaps. Review tracking systems.	
October 2021– December 2021		Facilitate meetings with the 3 practices to determine strengths, challenges and any gaps. Review tracking systems. Engage one other Pediatric practice.	
BUDGET PERIOD 5			
January 2022 – March 2022	Editing and maintenance of 10 online videos and manuals.	Facilitate meetings with the 4 practices to determine strengths, challenges and any gaps. Review tracking systems. Outreach to Pediatricians	Continue utilization of the electronic record. Consultation with eHana for maintenance, updates and enhancements as needed. Continued collaboration with the CSAs on best-practices. Track data and report on outcomes as required.
April 2022 – June 2022		Facilitate meetings with the 4 practices to determine strengths, challenges and any gaps. Review tracking systems.	
July 2022 – September 2022		Facilitate meetings with the 4 practices to determine strengths, challenges and any gaps. Review tracking systems.	
October 2022 – December 2022		Facilitate meetings with the 4 practices to determine strengths, challenges and any gaps. Review tracking systems.	

D. Budget Report and Budget Narrative – (Attachments B & C Attached.)

F. SUSTAINABILITY PLAN

PROJECT 1 Online Video Library	**PROJECT 2** Village Pediatrics – Pediatric Outreach and Partnership	**PROJECT 3** Wraparound Strength-Based Electronic Record
The plan is to develop and maintain the online video library, assuring quality, content and relevance. Access additional resources through grant and CSA revenue as census increases.	Through efforts of the Outreach Coordinator, it is expected that CSA census will increase by 10% each year over the 5-year budget period, thus providing resources to off-set the cost of the Outreach Coordinator's salary, fringe and benefits, travel, materials and other related expenses in subsequent years.	At the end of the 5-year period, the enhanced electronic record will be fully implemented; license expense for Mass HIWay, eHana professional service fees for continued upgrade and improvement will be expensed to the CSA program as needed.

SECTION 6.5 COORDINATION TO IMPROVE INTEGRATION OF BEHAVIORAL AND PHYSICAL HEALTH CARE:

A. BIDIRECTIONAL COMMUNICATION BETWEEN THE BIDDER AND PEDIATRIC PRACTICES:

BAMSI Helpline Program currently has a relationship with Village Pediatrics in Brockton. A staff is on-site at Village Pediatrics 5 hours a week to meet face-to-face with physicians, nurses, social worker and contracted mental health counselors to share information and receive referrals. The staff is also available to meet with patients to provide information, referrals, and access to community resources/basic needs. BAMSI will seek to enhance and build upon this model to provide a dedicated person to be on site at multiple pediatric offices within the Brockton catchment area each week. This collaboration with pediatric practices is described in section 6.4 as a project to improve Operational Infrastructure. Developing a new role for "Outreach and Marketing" would allow continued communication and collaboration with Village Pediatrics and other pediatric/physician practices in the Brockton area.

Village Pediatrics is exploring ways in which to allow the BAMSI staff security access for use of their electronic system. As BAMSI links to other pediatric practices, this option will also be explored. BAMSI currently uses eHana as its electronic health record/vendor, which has Health Information Service Provider (HISP) capability. In addition, BAMSI utilizes the Mass HIway to provide secure email and referral/data exchange with local medical/healthcare providers, under a Connected Communities Grant funded by the Massachusetts eHealth Institute (MeHi). BAMSI will extend that capability to the CSA as part of its proposed DSRIP Technology project to create interoperability with EOHHS/ACOs/MCOs, primary care providers, and potentially youth/families. A portion of BAMSI's DSRIP funds will further support enrollment and integration of the CSA program with the Mass HIway. A plan has been formulated with eHana which will support this effort through its HISP and will also include technical onboarding, project management, and ongoing training to support sustainability. BAMSI also plans to purchase and supply ICC staff with encrypted devices to enhance their capacity to mobilize to community locations while ensuring the protection of health information. (See Section 6.4 for more detail about proposed project for Technology).

B. REFERRAL MANAGEMENT PROTOCOLS FOR FOLLOW-UP AND INFORMATIONAL SHARING:

Currently BAMSI receives referrals face-to-face, by phone, fax, and/or email. Referrals are received from families, providers, clinicians, schools, pediatricians, nurses, hospitals, CBATS, etc. The CSA protocol is to contact the family referred within 24 hours of the referral receipt. If unable to reach the family within a week, outreach occurs with the referral source for collaboration, assistance, and follow-up. Once a family enrolls with the CSA a release of information is obtained for the Primary Care Provider and other involved medical/healthcare providers. To enhance existing practice, BAMSI CSA will include the "Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form" in all intake packets and send to the PCP on the first day of service. All CSA referrals are tracked and logged in our referral database.

C. TEAM-BASED TREATMENT PLANNING IN COLLABORATION WITH PEDIATRIC PRACTICES:

The CSA Care Coordinator(s) invites a representative from the Pediatrician's office to participate in the identified youth's care planning team, if the youth has a major medical diagnosis or is receiving psychotropic medications from their PCP. It has been a challenge for those

from pediatrician offices to participate in these meetings (face to face or by conference call) due to volume of their work. If unable to attend however, an "Absent Partner" form is sent for completion and returned with any updates/questions for the team. This allows pediatrician inclusion and connection with the team on an ongoing basis.

Skype and video conferencing technology is being explored as an additional tool for encouraging pediatricians/PCPs to join care plan meetings, which may be more convenient for them. We are invested in building a more integrated, collaborative, holistic approach and are thinking creatively of other ways to include every pediatrician's office in the care planning process. One idea is to identify a triage nurse or social worker within the practice to act as a liaison with the CSA. In the coming months, BAMSI will reach out to all local pediatrician offices with an invitation to attend a "Planning Breakfast". This approach has been effective in strengthening collaboration with local schools and community organizations. We plan to engage Dr. David Howell, our partner at Village Pediatrics, to provide a keynote address sharing his experience and success with the BAMSI/Village Pediatric partnership. This event will also include opportunities to dialogue with other health care professionals on ways to enhance communication on behalf of children/youth served, especially around team-based planning and care coordination. Included in our proposal is the addition of an Outreach/Marketing Coordinator to educate and link with pediatrician offices and other physical health care providers.

We will seek to improve our evidenced based practices such as Wraparound Certification for all staff, and Reflective Supervision for supervisors by collaborating with one other Southeast CSA to develop training videos for Tier 1 and Tier 2 and Coaching Certification (See Section 6.4, Workforce Development project description) and provide opportunity for leadership to attend Reflective Supervision training. We will use our "Planning Breakfast" to share this information and learn from pediatricians/PCPs about patient needs and treatments recommended to align our training strategy.

D. TIMELY ACCESS TO ICC SERVICES:

BAMSI CSA has an Intake Coordinator who contacts families within 24 hours of receiving a referral. Once the family has consented to the service, an intake is scheduled. The family is offered an appointment within 3 business days. Every effort is made to accommodate the family's time constraints and the family may choose to have the intake at the BAMSI office, their home, or another location of their choice. BAMSI intends to improve upon this by offering the Outreach Coordinator or Intake Team who can respond to the PCP's office to complete an intake during scheduled days/times. This will be discussed at the "Planning Breakfast" to determine the specific needs and preferences of the various health care providers.

As a result of the ACO/MCO and Community Partner collaboration, BAMSI expects that CSA enrollment will increase (See 6.4.E Sustainability). BAMSI will closely monitor the need to hire additional staff in order to continue timely access to services in compliance with State mandates and regulations.

E. CONNECTIONS TO SOCIAL SERVICES:

BAMSIs Helpline serves as an information, referral and advocacy program to the Greater Brockton community and beyond. Services include access to emergency assistance and basic needs, including rent, utility, and emergency resources as well as referrals and navigation support to other social services. BAMSI has longstanding relationships with local social service/community agencies, public sector Departments and has its own broad network of services that maximizes resources, and offers a full spectrum of services/supports to youth and families. BAMSIs Helpline is co-located with the CSA. Care Coordinators and Family Partners frequently connect families directly with this unique resource.

BAMSI will further enhance this resource by developing informational DVDs that can be used in physician waiting rooms and at pediatric offices so patients can learn about local social services. To quote Dr. Howell we need to move from "a healthcare model to a more human care model". This is one of the many ways we hope to achieve that sentiment.

In addition, the LTSS and BH Community Partner which BAMSI has partnered with has proposed PRAPARE as its Social Determinants of Health Screening Tool to better assess individual's needs and measure progress in meeting those needs. If approved, this tool will be embedded in the BAMSI eHR. Either this, or our current social needs assessment tool, will be used at CSA intake and by the Outreach/Marketing Coordinator at pediatric offices.

CSA Budget Report

Bay State Community Services

Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites	2	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate	NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)	175	130	145	155	165	175	
Estimated Funds	$ 176,700.00	$ 91,000	$ 60,900	$ 46,500	$ 43,560	$ 21,000	**$ 439,660**
At- Risk Withhold Rate			5%	10%	15%	20%	
Withhold			$ 3,045	$ 4,650	$ 6,534	$ 4,200	**$ 18,429**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 176,700.00	$ 91,000	$ 57,855	$ 41,850	$ 37,026	$ 16,800	**$ 421,231.00**

Investment Projects	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Project 1 Name: EHR Enhancements							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ 56,000	$ 26,000	$ 8,000	$ 4,000	$ 4,000	$ 4,000	**$ 102,000**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 1 Total	$ 56,000	$ 26,000	$ 8,000	$ 4,000	$ 4,000	$ 4,000	**$ 102,000**
Project 2 Name: Implementation of Office 365							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ 6,971	$ -	$ -	$ -	$ -	$ -	**$ 6,971**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 2 Total	$ 6,971	$ -	$ -	$ -	$ -	$ -	**$ 6,971**
Project 3 Name: *Purchase of Lap Tops and Signature Pads*							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ 28,600	$ -	$ -	$ 7,500	$ 3,750	$ 5,250	**$ 45,100**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**

Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 3 Total		$ 28,600	$ -	$ -	$ 7,500	$ 3,750	$ 5,250	**$ 45,100**

Project 4 Name: Wrapaound Credentialing

DSRIP Goal(s) Addressed:	Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*
	Goal 2:	*Optional*
	Goal 3:	*Optional*

Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses		$ 15,147	$ 12,500	$ 3,380	$ -	$ -	$ 3,750	**$ 34,777**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 4 Total		$ 15,147	$ 12,500	$ 3,380	$ -	$ -	$ 3,750	**$ 34,777**

Project 5 Name: Medical and Behavioral Health Intergration Training

DSRIP Goal(s) Addressed:	Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*
	Goal 2:	*Optional*
	Goal 3:	*Optional*

Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses		$ 8,000	$ 1,600	$ -	$ 1,600	$ 1,600	$ 1,600	**$ 14,400**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 5 Total		$ 8,000	$ 1,600	$ -	$ 1,600	$ 1,600	$ 1,600	**$ 14,400**

Project 6 Name: *Reflective Supervision Training*

DSRIP Goal(s) Addressed:	Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*
	Goal 2:	*Optional*
	Goal 3:	*Optional*

Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses		$ 3,350	$ -	$ -	$ -	$ -	$ -	**$ 3,350**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 6 Total		$ 3,350	$ -	$ -	$ -	$ -	$ -	**$ 3,350**

Project 7 Name: Recruitment and Retention Specialist

DSRIP Goal(s) Addressed:	Goal 1:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*
	Goal 2:	*Optional*
	Goal 3:	*Optional*

Technology

IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development								
Workforce Development staffing including Fringe		$ 16,275	$ 20,213	$ 34,650	$ 23,100	$ 23,100	$ -	**$ 117,338**
Recruitment Expenses		$ 2,285					$ -	**$ 2,285**
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 7 Total		$ 18,560	$ 20,213	$ 34,650	$ 23,100	$ 23,100	$ -	**$ 119,623**
Project 8 Name: *Outreach to Primary Care and Community Partner*								
DSRIP Goal(s) Addressed:	Goal 1:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
	Goal 2:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure								
Operation Staffing including Fringe		$ 17,696	$ 19,323	$ 4,133	$ -	$ -	$ -	**$ 41,152**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 8 Total		$ 17,696	$ 19,323	$ 4,133	$ -	$ -	$ -	**$ 41,152**
Total Project Costs		$ 154,323	$ 79,636	$ 50,163	$ 36,200	$ 32,450	$ 14,600	**$ 367,372**
Indirect Costs/ Administrative Overhead Rate	14.50%	$ 22,377	$ 11,547	$ 7,274	$ 5,249	$ 4,705	$ 2,117	**$ 53,269**
Investment Projects Total		$ 176,700	$ 91,183	$ 57,437	$ 41,449	$ 37,155	$ 16,717	**$ 420,641**

Training Expenses

Description of Expense	Cost
50% of Consultant cost to conduct Reflective Supervision training. The other 50% of the cost will be paid by BAMSI	$ 3,350.00
Total Training Expenses	**$ 3,350.00**

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

This amount was calculated using 24 hours of training over a four day period plus 6 coaching hours subsequent to training at a rate of $223.33/hour (30 hours X 223.33=$6,700. 50% of total cost is $3,350.

Reflective Supervision is a relationship-based practice that expands the idea that supervision is a context for learning and professional development. In reflective supervision, the relationship between supervisor and supervisee models the relationships between a provider and client in a helping relationship. Through its model of collaboration with and support of clinicians and other providers, Reflective Supervision strengthens the practice of trauma-informed care. Training our CSA Program Managers and Supervisors in the Reflective Supervision model will help to improve staff job satisfaction, improve staff retention, and improve outcomes for families being served by the CSAs. This training will be attended by 1 Program Manager, 2 Program directors and 4 Supervisors.

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS March 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
Project #1	EHR Enhancements	Enhance existing EHR to make documentation more reflective of hi-fidelity Wraparound	12/01/17	12/31/22	**Technology**	Development/adaptation of EHR and/or care management system	Working group will have met 3-5 times and a draft of a Wraparound assessment and Care Plan will be available.	Draft of Wraparound assessment and Care Plan will be presented to Network Managers for input.						
Project #2	Implementation of Office 365	Increase security and improve mobile access to information	12/01/17	03/31/18	**Technology**	Other Technology Expenses	Purchase by 1/1/18;Installation completed by 3/31/18	Staff fully utilizing new email system						
Project #3	Signature Pads and Lap Tops	Increase active participation in care planning process and signing of documents	01/01/18	03/31/18	**Technology**	Technology for Service Delivery	Purchase by 1/1/18; distribution to staff complete by 3/31/18	Staff fully utilizing signature pads and laptops.						
Project #4	Wraparound Credentialing	Ensure families receive hi-fidelity Wraparound Services	12/01/17	12/31/19	**Workforce Development**	Training Expenses	Purchase of training manuals. Contract signed with Silver Lake Productions. Certified Coach will be retained and credentialing activities will be in process.	Training Manuals will be available to staff. Signed contract will be available for review. Certified Coach will be working with staff.						
Project #5	Medical Behavioral Health Training	Provide staff with the skills to coordinate care with youth and medical providers	11/06/17	12/21/22	**Workforce Development**	Training Expenses	2 staff will be certificed and 8 staff will be in process of certification.	2 staff will be certified.						
Project #6	Reflective Supervision	Ensure effective supervision and maintain staff	01/01/18	05/31/18	**Workforce Development**	Training Expenses	7 staff will have participated in the Reflective Supervision Training.	2 Supervisors from each site and 3 program director level staff will have completed the training portion.						
Project #7	Recruitment and Retention Specialist	To increase staffing and ensure timely access to Wraparound	11/01/17	12/31/21	**Workforce Development**	Recruitment Expenses	Position posted 11/1/17. Interviews completed by 12/15/17. Position filled 1/1/18	The Recruitment Specialist has completed New Hire Orientation and has began to screen candidates for CSA positions.						
Project #8	Outreach to Primary Care and Community Providers	To increase referrals and educate community partners	11/01/17	12/31/19	**Operational Infrastructure**	Operation Staffing including Fringe	The CSA staff will schedule presentations at a mimumum of 8 Pediatric practices to offer on site CSA availablity.	Each site will have working agreeements with 2 Pediatric practices.						

6.2 EXECUTIVE SUMMARY

Bay State Community Services (BSCS) greatly appreciates the opportunity, through this RFR, to assess our CSAs, review the lessons we have learned and develop a 5 year plan that will ensure our CSAs are successful in fully meeting the needs of the youth, families and funders.

A. Current Performance – BSCS is proud to offer Intensive Care Coordination (ICC) services through our two CSA's. Although the details of the Developmental Plans differ for each site, the overarching theme that impacts the work we do is workforce development—specifically recruiting, hiring and maintaining quality staff who embrace the CSA High Fidelity Wraparound Model.

Historically, the Plymouth CSA has experienced positive reviews in Development Plans focused on specific and identifiable Wraparound skills, as well as documentation recommendations. In 2015 the program director, who was part of the writing, implementation and training process of the Plymouth CSA, left her position. Even with aggressive outreach, unfortunately it took us nine months to find a qualified candidate for this critical position. During this time, the staff did not have the level of support and guidance usually upheld by BSCS; we take responsibility for not maintaining this level of support. In order to ensure that this would not happen again, BSCS has restructured our leadership team in Plymouth by adding a site director, filled by Imani Seunarine. In addition, our Vice President of Children's Services, Theresa Burke, is now responsible for the oversight of the program. Both of these individuals are highly trained and qualified, having extensive experience with the Wraparound model. This restructuring immediately stabilized the program and has addressed the concerns on the Plymouth Development Plan.

The Coastal CSA has also been successful since the inception of the program. We are confident in our fidelity to the model and have been given positive feedback on our documentation. However, we have experienced significant challenges in recruiting, hiring and maintaining staff; therefore, the numbers of families that we serve is low. We have attempted numerous strategies to address this issue and currently have a stable and committed staff.

B. Strengths and Needs – The strengths of BSCS include: our commitment to our communities, deep desire to support our families and the dedication of our staff and leadership team to fulfilling the needs of those we serve. Such strengths were especially emphasized when the Plymouth CSA began to struggle. Our leadership team prioritized the Plymouth CSA and took action by restructuring positions in order to ensure that the CSA had the support and oversight needed to be successful. As in this situation, we do experience staff leaving; however, we have several core staff members who have been with the agency since the beginning of the program and are committed to staying in the program. These core staff members are fully invested in the Wraparound model and are champions in maintaining fidelity to the model.

The overwhelming need for the success of our CSAs is the recruitment and retainment of committed and qualified staff that have a passion for the Wraparound model. In writing this RFR, there were many discussions around the challenges we face and the strategies we need to implement in order to find staff that have the ability to effectively meet the needs of our youth, families and funders.

C. Timely Access – As previously highlighted, staffing is fundamental to improving access to ICC services. Having staff that are available and trained allows us to respond more quickly and efficiently to the needs of our youth and families. As part of our 5 year investment plan, we are proposing numerous ways to effectively address this issue. Some of these proposals include: hiring a specialized recruiter, offering training and certification to staff, enhancing our electronic health records system, conducting outreach. Please see Section 6.5 (D) for additional details.

D. Care Improvement Plans – Our first strategy for improving care coordination, care planning and management is to provide training to our staff that supports these key elements. This training will include supporting staff in becoming certified Wraparound facilitators.

The second strategy for improving care coordination, care planning and care management is to enhance our Electronic Health Record (EHR). Currently, staff members are trained on the best practices in Wraparound documentation. However, the EHR format is more in line with the medical model and not necessarily conducive to Wraparound practices. Therefore, by enhancing our EHR, the BSCS staff will be able to focus on the Wraparound model and services instead of on the difficulties faced in documenting services in the current system. Both of these initiatives will all address adherences to quality measures.

E. Performance Improvement Plans – The CSA teams appreciate the time and effort that goes into the compilation of the Mass Practice Review (MPR) and the Wraparound Provider Practice Analysis which includes findings from the Team Observation (TOM) and the Wraparound Fidelity Index (WFI). We have used this information to develop our Continuous Quality Improvement (CQI) goals for our CSAs.

The Coastal CSA received an average score of 3.9 on the MPR and the Plymouth CSA received an average score of 3.6, placing both programs in the upper portion of fair practice. It should be noted that the Plymouth CSA score was calculated based on one evaluation due to our inability to complete two individual case reviews. Our goal for both programs is to be in the high range of the good to exemplary practice score. A considerable strength of the Coastal CSA was team participation (5), Youth Engagement (4.5) and Care Coordination (4.5). Although still in the fair practice range, Assessment (3) is an area that we are addressing through the enhancement of our EHR. The Plymouth score identifies the same goals.

We are proud to announce that the Coastal CSA TOM score was 97%. However, we understand that we must improve our Natural and Community supports (73%) and plan to do so by having natural and community supports attend team meetings. In addition, we have identified Natural and Community Supports (63%) as an area to improve. The WFI-EZ score was 69%, as compared to the state average of 69.9%.

The Plymouth CSA TOM score was 91%. We have identified the Natural and Community Supports (39%) as an area that needs dramatic improvement. Again, the areas of Natural Supports (66%) are being addressed. The score on the MA WFI 4 was 82%, as compared to the state average of 81%.

In looking at this data BSCS plans to develop specific Continuous Quality Improvement (CQI) initiatives to improve on our scores by focusing on the following areas: training staff on motivational interviewing, pursuing certification in the Wraparound process and participating in the statewide training series that is being developed. Special attention will be given to the Natural and Community supports for innovative and best practices. An example of this would be additional training on the use of the Absent Partner Wraparound Participation Form and how to effectively use this form to improve outcomes.

F. Coordination Improvement Plans – After reviewing our Performance Based on Quality score, assessing our development plan, and speaking with the staff and leadership team, we determined it would be beneficial to have our staff participate in the U-Mass Medical Center for Integrated Primary Care (CIPC) training. This extensive on-line training with live coaching will provide our staff with the knowledge, resources and confidence to work directly with the pediatric practices, community health centers and hospital systems. The curriculum includes the following topic areas: Creating and Managing an Integrated Primary Care Practice, Bio-Psycho-Social Treatment, Dealing with Substances and Pain in Primary Care, Behavioral Health and Pediatrics, Serious Mental Illness, Population Health in Primary Care and Families, Community and Culture. In addition, U-Mass offers an abbreviated specialized course on Behavioral Health in Pediatrics. It includes the following additional topics: Behavioral Health in the Primary Care of Children, Practicing as a Behavioral Health Clinician in Pediatric Care and Challenging Populations. We will review these trainings based on the staff and community needs.

6.3 POPULATIONS SERVED AND COMMUNITY ENGAGEMENT

A. Member Populations – As part of our process in submitting this RFR, we wanted to fully understand the Members and the communities we are serving. We asked: Who are we serving in our CSA's? Are we providing service in all of our cities and towns? What is the age and gender of the youth? Are we meeting the needs of the diverse cultures and ethnicities in our communities? We believed that understanding this information would guide us in how best to use the funds that are being made available. We took the time to carefully analyze our service data for calendar year 2016 and have included a brief summary below.

The Plymouth CSA serves a large geography including 19 towns. They have served 322 families from 27 different communities in calendar year 2016. Of the youth served, we had 144 females and 178 males, ranging in age from 3-21. This data breaks down as follows: 89 youth between the ages of 7-10, 98 youth between the ages of 11-14, 99 youth between the ages of 15-18, and 7 young adults. The demographics for this area have been identified as primarily white and English speaking; however, some of our communities are welcoming more Brazilian, Portuguese and Cape Verdean families. Through this CSA we have provided services for 18 families identified as African American, 4 Native American, 13 Bi-Racial, 3 Cape Verdean, 19 Hispanic and 5 other families who chose not to identify their ethnicity.

The Coastal CSA serves an area encompassed by 10 cities and towns. The CSA staff served 161 families from 13 different communities. Of the youth served, we supported 67 females and 92 males, ranging in age from 3-20. This data breaks down as follows: 23 youth between the ages of 3-6, 42 youth between the ages of 7-10, 48 youth between the age of 11-14, 42 youth between the age of 15-18, and 6 young adults. The area is also primarily a white and English speaking demographic, with some of our communities having a large Asian population. Twelve families identified as African American, 1 Native American, 4 Asian, 3 Bi-Racial, 1 Cape Verdean, 1 Hawaiian and Pacific Islander, 8 Hispanic and 2 families who chose not to identify their ethnicity.

Clearly understanding and analyzing this information has guided our thought process in regards to the projects we are proposing. We hope these proposed projects will not only promote health and wellbeing, but will also initiate and maintain the engagement of our youth and families. Employing a CSA Recruitment and Retention Specialist will not only assist us in hiring qualified staff, but the Specialist will have a mandate to reach out and engage staff from the cultures we are committed to serving, thereby improving access to care in our catchment areas for families with cultural and linguistic needs.

Further, as part of our proposal, our staff will be trained in medical and behavioral health integration. This specialized skill set will allow our staff to fully understand how to engage with primary care physicians. This will better equip the staff in supporting our families, helping them to understand the importance of regular health and dental wellness visits for the overall well-being of their child.

In looking at our identified service area, we are proud to have provided services in each of the cities and towns in our catchment areas. As we analyze this data, we are able to identify some cities and towns that would benefit from additional education and outreach. As part of our SOC, we will reach out to community providers and PCPs in these areas to increase engagement.

B. Community Relationships – The success of our CSAs are intricately linked to the programs offerings and the agency's commitment to making authentic connections with our community partners. As the CSA, it is our responsibility to develop strong, supportive and trusting relationships with everyone throughout our communities.

As a large agency, BSCS has numerous formal, informal and collaborative agreements with the continuum of child caring services systems. We work closely with these partners to ensure that

our youth and families have access to the supports they identify in their care plans. The following are examples of our current and planned relationships, and how they will be leveraged to improve the quality of ICC services.

Family Organizations/Advocacy Groups – As the host of the Quincy Family Resource Center (QFRC), we work closely with family organizations such as PIN, PPAL and NAMI. This strong relationship enables us to reach out to families in need and provide ICC support. We will continue to nurture these strong relationships to be viewed as strength-based support for families.

Schools – As a large multi service center, BSCS provides numerous offerings in the schools. Most recently we have developed a curriculum for the Quincy Public Schools (QPS) to assess Substance Use Disorders (SUD), and supportive mental health services. This strong relationship has ensured that youth in the QPS who would benefit from ICC have immediate access. Developing personal and responsive relationships ensures that the school personnel will reach out when a family needs assistance. Our clinic services plan to increase this training to other school systems and will ensure coordination with the CSAs.

Child Care Providers – Although we work with numerous child care providers, we are currently working on increasing our collaboration with the STAR's child care provider. As one of the South Shore's largest providers for DCF, we want to offer resources and supports to these families. This enhanced collaboration is exploring placing CSA staff in the day care sites.

Community Based Organizations – Our strong SOC demonstrate our connection to our community partners. Our communication and collaboration ensures cross referral and an understanding of the CSA service. We will leverage our existing relationships with organizations such as Quincy Asian Resource Center to ensure that we reach everyone in our community.

Behavioral Health Service Providers – As a CBHI provider, we understand the continuum of care available to our youth and family. We work closely with behavioral health serving agencies to inform them of the ICC service and how it will support their clinical work.

Child Serving State Agencies – BSCS is the Lead Agency for both the Plymouth and Coastal DCF offices. Our Lead staff is well educated on the CSA services and work collaboratively with DCF to identify families who would benefit from ICC.

Courts – BSCS has numerous contracts with the Department of Corrections and the court/legal system. When a parent is involved in a legal matter, we are able to use the agency's resources to educate and inform the family on the corrections system and practices. Additionally, QFRC staff is in court each week to offer support and resources to youth and families involved with the CSA. QFRC staff regularly refers to CSA services, fully understanding and recognizing the needs of the youth and families and how CSA services can benefit them.

Housing/Shelter – BSCS longstanding collaborative relationship with Fr. Bill's/Mainspring enables us to effectively assist our families in navigating housing and shelter resources.

Primary Care Physician/Community Health Center – BSCS has a positive working relationship with Manet Community Health Center, Quincy Medical Center and South Shore Hospital, as we provide various supportive services to all of them. We are currently in discussions with Manet and South Shore Hospital to locate a Senior Care Coordinator onsite in their systems to support the behavioral health needs of their patients.

C. Alignment of Partnerships and Projects – BSCS is proposing the following projects to support the current and planned partnerships.

Medical and Behavioral Health Integration Training Project – CSA staff will participate in this intensive training which will improve collaboration with PCPs, Pediatricians, Community Health Centers and other integrated health services. This project will directly benefit our planned increase collaboration with Manet and with South Shore Hospital's pediatric group.

Training – We are proposing two initiatives to address the training needs including: Reflective Supervision Training , and Wraparound Certifications. .

Recruitment and Retention Specialist – Having a dedicated person will ensure that when our community partners are looking for services, we have staff who are readily available.

EHR Enhancements – Providing our partners with documentation that clearly reflects the Wraparound process and principles will ensure that they understand the service and are invested in the process.

Outreach to Primary Care and Community Partners – The CSA's
CSA staff will have dedicated time in Primary Care settings to educate medical staff on SED and CSA services and be available to accept referrals.

6.4 BIDDER'S PROPOSED PROJECT(S) AND INVESTMENT PLAN

A. Project #1 Description

1. **Project Title –** **Electronic Health Records (EHR) Enhancements**

2. **Goal -** Enhance existing EHR to 1) make documentation more reflective of best practices and fidelity to strengths-based model, 2) connect to the Mass HIway, 3) deploy interoperability of the CANS Assessment, and 4) support Quality Measure requirements.

3. **Scope -** BSCS has substantial demonstrated experience successfully managing implementation, deployment and support of EHR and other complex technology initiatives. We use eHana's Software-as-a-Service (SaaS) EHR, which is certified Meaningful Use Complete by Drummond Group (Certification Number 14.04.04.25 94.eHan.16.0.1.160728) and is deployed in community-based provider organizations throughout Massachusetts.

   The ONC-Certified version of the eHana EHR includes features and functionality intended to support integrated and collaborative models of care, including: Patient Portal functionality; Standardized data exchange formats (including Clinical Document Architecture (CDA) support); Transmission via DIRECT Health Information Service Provider (HISP) to the Mass HIway or other partners; Clinical Quality Measure and Automated Measure reporting; and Patient Educational Resource sharing and tracking.

   These features support EOHHS's goal of developing secure mechanisms to support data exchange not only with EOHHS and payers, but with the ICC-Engaged Members themselves. By way of example, Comprehensive Assessments, Individual Care Plans, and other information intended to support transitions of care could be shared via the Patient Portal or transmitted electronically via the Mass HIway.

   BSCS' vendor, eHana, also continues to make investments in the areas of interoperability and data exchange, including: a) working with new MassHealth ACOs to coordinate technology deployment; b) applying for and receiving the EOHHS grant-funded CANS interoperability project; and c) investing in new HISP technologies and connections to support emerging use-cases (such as the upcoming statewide Event Notification System).

   Wraparound/Strengths-Based Documentation - BSCS, its EHR vendor, and other stakeholders will collaborate on development of a best-practice Wraparound/Strengths-Based documentation module, which will supplement, or, in some cases, replace elements of its existing data-tracking system. Screenings, assessments, plans, and service documentation will be reviewed and potentially updated based on best practices and fidelity to a strengths-based model. This project is anticipated to include consulting/business analysis, project management, technical development, training, and support.

   Connectivity to the Mass HIway - A portion of BSCS' DSRIP funds will support enrollment and integration of the CSA program with the Mass HIway. Such a project will allow the CSA to interoperate with EOHHS, ACOs, primary care providers, and potentially clients and their families. This project is supported by BSCS' EHR vendor and its Health Information Service Provider (HISP), and will include technical onboarding, project management, and training.

   CANS Interoperability - BSCS' EHR vendor, eHana, is currently implementing interoperability of the CANS assessment, and BSCS anticipates utilizing functionality when it is deployed. This will enable more efficient data collection and reporting, with a small support overhead since the CANS will be completed within BSCS' EHR. This

project will include software licensing, project management, and training.

Quality/Accountability Measure Reporting - As part of the DSRIP application, BSCS will work closely with its EHR vendor, eHana, to implement data tracking, dashboarding, and reporting necessary to support Quality Measure capture, management, and submission in a manner consistent with EOHHS requirements. This work may include business process analysis, EHR modifications, reporting enhancements, and data export integrations (for reporting quality measures in a structure format). Quality/Accountability Measure technologies will support:

(a) **Claims/Encounter Only Measures.** BSCS will work with eHana to automate, where possible, the import/collection of quality data (including, for example, data supplied by EOHHS). Where possible, BSCS will work with EOHHS, ACOs, MCOs, other health care providers, and community stakeholders to build data interchanges to support real-time quality analytics.

(b) **Chart Review Measures.** BSCS will use existing tools and technologies, such as auditor logins, encrypted PDF exports, and data analytics to support submission of the Quality Measures Report to EOHHS and to provide access to additional data or information necessary to audit or validate submitted data.

(c) **Engaged Enrollee Experience Survey.** BSCS will support EOHHS in execution of the Engaged Enrollee Experience Survey.

4. **Deliverables -** A revised CSA module in eHana that offers the features described above.

5. **DSRIP Use -** Payment to eHana in the amount of $102,000 for a collaborative effort with other CSAs to enhance the CSA module as described under the Scope section above. The allocation of this amount between the above-named projects is outlined in the budget and the budget narrative.

6. **Resources -** BSCS will provide a Senior Program Manager to be part of a working group to design and implement the enhanced eHana module. Additionally, BSCS' VP of Children's Services, both CSA Program Directors, the EHR Coordinator and IT Consultant will be involved in the implementation.

7. **Funds Allocation -** The payment of $102,000 to eHana will be made using DSRIP funding and will be evenly distributed between the Plymouth and Coastal CSA programs.

8. **Measurement -**

Goal: Documentation will reflect best practice in Wraparound.

a) Specific Measures to Evaluate Impact

i) Staff Satisfaction Survey
ii) Family and Youth Satisfaction Survey
iii) MCO Record Review Results

b) Timeframe for evaluation and performance

i) Evaluation will begin 6 months after implementation of documentation and once yearly thereafter.

c) Proposed Goals for Measure

i) Staff Satisfaction Survey will be distributed 6 months after implementation of new documentation. Eighty percent of staff will report favorably on new documentation.
ii) Family and Youth Survey will be completed and 70% of families will report that they agree or highly agree that documentation is easy to understand and helpful to family.
iii) Mass Practice Review (MPR) findings will be used as a comparative analysis in subsequent MPR's with the expectations that the programs will attain Good to Exemplary Best Practices.

d) Data Collection

i) Human Resources will distribute surveys to CSA staff 6 months after implementation of new documentation.
ii) CSA Program Director's will distribute survey to CSA families with targeted questions related to satisfaction of documentation.

e) Staff Responsible for Evaluation

i) VP Human Resources - Julie Chirillo
ii) CSA Program Directors
iii) VP of Children's Services - Theresa Burke

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B. Project #1 Team Description

1. **Organizational Chart –** See Attachment.

2. **Current Staff -** See Job Description Attachments - Marta Reese, CFO; Jerry Forde, IT Consultant; Theresa Burke, VP Children's Services; Imani Seunarine, Plymouth Site Director

3. **Staff to Be Hired –** None.

4. **Roles and Responsibilities -** Roles and responsibilities will be determined upon commencement of the eHana sponsored working group.

5. **Project Management -** This project will be managed primarily by eHana.

C. Project #1 Implementation Plan and Timeline

See Attachment 1- BSCS Project Implementation Timeline

E. Project #1 Sustainability - This project will be completed within the contract term and will be funded in total by DSRIP funding.

A. Project #2 Description

1. **Project Title – Implementation of Office 365**

2. **Goal -** Problem -BSCS' current email system is a hosted internet based POP (Post Office Protocol) system. A POP system is a limited protocol that lets your email program do nothing but download messages to each individuals computer or device. Because the emails are on each employee's hard drive, emails are not backed up. Additionally, with a POP email system, it is not possible to access the same email account from multiple computers or devices and have actions synchronize between them. Finally, security or encryption of email can only be accomplished by purchasing each email user a digital certificate, which is very cumbersome.

   Solution-The solution is to convert from a POP internet based email system to Microsoft Office 365, which is a cloud-based version of Microsoft's Office suite of enterprise-grade productivity applications (Word, Excel, PowerPoint, Outlook, etc.).

   By implementing Microsoft Office 365, the agency will be able to ensure a higher level of security with respect to transmission of information through email. This more secure communication system will be important in communicating with ACO's, Primary Care Providers, and ICC engaged members. Additionally, email will now be available on all types of devices providing employees with greater mobile access to critical information. Finally, all emails will be backed up by Microsoft.

3. **Scope -** This project would be completed during the Preparation Budget Period. Also, see timeline in Section C.

4. **Deliverables –** An upgraded email system to Office 365.

5. **DSRIP Use -** This agencywide project is estimated to cost $40,000. This amount includes 280 IT Consultant hours at a rate of $100 per hour ($28,000), and 800 hours of IT interns at $15 per hour ($12,000) for a total of $40,000. This estimated project cost is based on

converting 373 agencywide computers to Office 365. Plymouth CSA has 41 computers which represents 11% of the total. Coastal CSA has 24 computers, which represents 6% of the total. These percentages were applied to the total project costs of $40,000 to determine the pro-rated portion of the project to be funded by the CSA DSRIP funds. Plymouth CSA would be allocated $4,397 and Coastal CSA would be allocated $2,574.

6. **Resources -** This project would be overseen by the agency's IT Committee, which is comprised of the IT Consultant, Chief Financial Officer, VP of Prevention Services and the Facilities Manager.

7. **Funds Allocation –** See #5 above.

8. **Measurement**

Goal: To ensure security of electronic communication and increase mobile access.

a) Specific Measures to Evaluate Impact

   i) Staff Satisfaction

b) Timeframe for evaluation

   i) Completed 3/31/19

c) Proposed Goals for Measure

   i) Seventy five percent of staff will report satisfaction with synchronization between devices and improved communication via shared calendars.

d) Data Collection

   i) The CFO and IT Director will conduct a survey via survey monkey.

e) Staff Responsible for Evaluation

   i) CFO - Marta Reese
   ii) IT Director - Jerry Forde

B. Project #2 Project Team Description

1. **Organizational Chart –**See Attachment.

2. **Current Staff -** See Job Description Attachments - Marta Reese, CFO; Alejandro Rivera, VP of Prevention Services; Jerry Forde, IT Consultant; Diane MacIver, Facilities Manager

3. **Staff to Be Hired –**10 IT Interns

4. **Roles and Responsibilities –** This project will be overseen primarily by BSCS' IT Consultant, but supported by the IT Committee. The IT Consultant will directly supervise the interns.

5. **Project Management –** See Timeline below.

C. Project #2 Implementation Plan and Timeline

See Attachment 1- BSCS Project Implementation Timeline

E. Project #2 Sustainability - This project will be completed within the contract term and the portion of the conversion related to the 2 CSAs will be funded by DSRIP funding.

A. Project #3 Description

1. **Project Title –** **Purchase of Laptops and Signature Pads**

2. **Goal -** To provide greater mobile access for ICC staff as well as more active participation of families in completing required documentation.

3. **Scope**

   - Purchase of 50 laptops: 28 in Prep Period, 10 in Period 3, 5 in Period 4 and 7 in Period 5

   - Purchase of 20 Signature Pads in Prep Period

4. **Deliverables –** Efficiencies and improved timeliness of clinical and billing documentation.

5. **DSRIP Use -** DSRIP funds in the amount of $45,100 will be used to purchase these laptops and signature pads.

6. **Resources –** IT Consultant and Facilities Manager

7. **Funds Allocation**

   - 10 laptops will be allocated to the Coastal CSA program ($7,500) and 18 will be allocated to the Plymouth CSA program ($13,500). Additionally, $200 per computer for IT set up is included in the allocation. ($5,600)

- 10 signature pads will be allocated to the Coastal CSA program ($1,000) and 10 will be allocated to the Plymouth CSA program ($1,000).

- **Funds allocation described above represents only Preparation Budget Period.**

8. Measurement
Goal: To ensure staff has equipment to complete required documentation in the field.

a) Specific Measures to Evaluate Impact

i) Staff satisfaction
ii) Signed Care Plans that are completed within required guidelines
iii) Better utilization of the EHR

b) Timeframe for evaluating performance

i) End of Budget Period 1 - 12/31/18

c) Proposed Goals for Measure

i) 75% of staff will be utilizing laptops and signature pads.
ii) 60% of Care Plan will be signed electronically.

d) Data Collection

i) Staff Satisfaction Surveys
ii) Generate reports from EHR.

e) Staff Responsible for Evaluation

i) VP, Human Resources – Julie Chirillo
ii) CSA Program Directors

B. Project #3 Project Team Description

1. Organizational Chart –See Attachment.

2. Current Staff - See Job Description Attachments - Jerry Forde, IT Consultant; Diane MacIver, Facilities Manager.

3. Staff to Be Hired – None.

4. **Roles and Responsibilities -** IT Consultant will purchase laptops and signature pads. The IT Consultant and the Facilities Manager will oversee set up and deployment.

5. **Project Management –** See above.

C. Project #3 Implementation Plan and Timeline

See Attachment 1- BSCS Project Implementation Timeline

A. Project #4 Description

1. **Project Title – Wraparound Credentialing**

2. **Goal -** To develop a comprehensive and sustainable employee training program that strengthens fidelity to the Wraparound Process and improves family outcomes by building employee care planning, care management, and care coordination skills.

3. **Scope –** We have identified Workforce Development as a crucial area for enhancement and will create a comprehensive and sustainable employee training program. In an effort to strengthen fidelity to Wraparound processes, BSCS seeks to enhance training and certification of High Fidelity Wraparound for staff. BSCS will partner with BAMSI to create a Video Library that depicts examples of wraparound practice, done according the standards of High Fidelity Wraparound. The videos will demonstrate the wraparound experience of a fictional family with complex behavioral health needs as they navigate the core meetings of the wraparound process. Additionally, BSCS will purchase textbooks and videos from Vroon Vandenberg. The training textbooks include detailed descriptions of how to deliver a high fidelity wraparound process as defined by Vroon Vandenberg Action Steps and Theory of Change. Additionally, BSCS is hiring a consultant to train and certify 10 staff as Wraparound Facilitators and 2 staff as Certified Coaches during the Prep period. Over the course of the project, BSCS will send 3 additional staff to the Redrock training and will secure more hours of coaching consultation. Credentialing staff as coaches allows the CSAs to build a sustainable High Fidelity Wraparound program. These initiatives seek to improve workforce development specifically in training, professional development and staff retention, with an emphasis on best practices to meet ICC enrolled members needs.

4. **Deliverables –** Purchase of training materials including Wraparound Textbooks and Vroon's Training DVDs, production of a complete set of 12 Videos to be used for training and certification. Employees will complete credentialing in Wraparound Certification (minimally Tier One) within 3 months of employment; BSCS will have several Certified Wraparound Coaches on staff, so training and certification of facilitators continues. Ongoing Wraparound training will be integrated into all aspects of supervision to meet the ongoing requirements of the MCEs.

5. **DSRIP Use –**Payment to Silver Lake Productions for creating Videos; Payment to Wraparound Coach consultant to certify staff and Coaches; Purchase of Textbooks and Training DVDs; and the cost of sending staff to the Redrock Training.

6. **Resources –** BSCS will allocate existing staff to this project**.** Additionally, laptops, computers, cell phones and Internet to access any online/video modules will also be provided. Training opportunities can be set up across both CSAs to improve the delivery of services and continuity across the organization.

7. **Funds Allocation –** The total cost of $34,777 will be covered with DSRIP funds and will be evenly distributed between the Plymouth and Coastal CSA programs. .

8. **Measurement**
   Goal: Strengthen fidelity to wraparound process.

a) Specific Measures to Evaluate Impact

   i) WFI-EZ Score
   ii) TOMS Score

b) Timeframe

   i) End of Budget Period 2 - 12/31/19

c) Proposed Goals for Measure

   i) WFI-EZ i Score to be at least at national mean level.
   ii) TOMS Score to be at least at national mean level.

d) Data Collection

   i) **WFI-EZ** and TOMS scores will be made available to us through the Wraparound Provider Practice Analysis Report.

e) Staff Responsible for Evaluation

   i) VP Children's Services - Theresa Burke

B. Project #4 Project Team Description

1. **Organizational Chart –**See Attachment.

2. **Current Staff -** See Job Description Attachments – Theresa Burke, VP Children's Services; Imani Seunarine, Plymouth Site Director; 2 CSA Program Directors; 2 Senior Family Partners.

3. **Staff to Be Hired –** None.

4. **Roles and Responsibilities –** VP Children's Services will support oversight of the project. Plymouth Site Director will support the implementation of the project. CSA Program Directors will support staff across sites signing up and completing required training. Program Supervisors will become Certified Wraparound Coaches.

5. **Project Management –** Weekly conference calls to discuss oversight and progress of project components until fully operationalized. Monthly meetings to discuss implementation, and quarterly meetings to ensure that measures are being met and goals are achieved.

C. Project #4 Implementation Plan and Timeline

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See Attachment 1- BSCS Project Implementation Timeline

E. Project #4 Sustainability – Program Supervisors who are Coach Certified will work with the CSA Program Directors to ensure that all staff is Tier 1 certified. BSCS has the goal of having at least 3 Certified Wraparound Coaches across the sites. This will allow for more staff to be certified across sites.

A. Project #5 Description

1. **Project Title – Medical and Behavioral Health Integration Training**

2. **Goal -** Improve medical understanding for staff working with children who are experiencing SED and have complex medical issues, thus, improving the collaboration with pediatric practices, increasing referral streams, and ultimately improving outcomes for families.

3. **Scope –** BSCS proposes partnering with UMASS Center for Integrated Primary Care to train staff across a number of modules to strengthen practice specifically in the areas listed below:

   - Behavioral Health in Primary Care of Children
   - Practicing as Behavioral Health Clinician in Pediatric Care and Challenging Populations
   - Creating and Managing an Integrated Primary Care Practice
   - Bio-Psycho-Social Treatment
   - Dealing with Substances and Pain in Primary Care
   - Behavioral Health and Pediatrics
   - Serious Mental Illness
   - Population Health in Primary Care

- Families, Community, Culture

4. **Deliverables –** Training in these areas culminates in a Certificate in Primary Care Behavioral Health for participants. Improved workforce development and improved timely access to services. http://www.umassmed.edu/cipc/pcbh/overview/

5. **DSRIP Use –** DSRIP funds in the amount of $14,400 will be used in the Prep Period and Budget Periods 1,3,4 and-5 to support Workforce Development in the area of Medical and Behavioral Health Integration. See Budget Narrative for detail.

6. **Resources –** Computers and telephones to allow for staff participation; relationships with pediatric practices/hospitals that can be leveraged to increase referral streams to help offset total costs. Supervisors will participate in training modules to support the development of further training for sustainability for all staff.

7. **Funds Allocation –** During the Prep Period the training costs for 10 participants ($800 per person) will be allocated as follows: Coastal CSA - 5 participants, Plymouth CSA - 5 participants.. See Budget Narrative for calculation. During Budget Periods1,3,4, and 5, an additional $1,600 per Budget Period will cover training for 8 additional participants . This amount will be evenly distributed between the Plymouth and Coastal CSA programs.

8. **Measurement**
   Goal: Increase staff's understanding of complex medical issues for enrolled youth.

a) Specific Measures to Evaluate Impact

   i) Number of staff that obtain Training and Primary Care Behavioral Health Certificate from U-Mass Program.

b) Timeframe

   i) End of Preparation Budget Period - 5/31/18
   ii) End of Budget Periods 1, 3, 4, and 5

c) Proposed Goals for Measure

   i) 80% of training attendees obtains certification.

d) Data Collection

   i) Upon completion of coursework, staff will submit verification of passing score.

e) Staff Responsible for Evaluation

   i) CSA Program Directors

B. Project #5 Project Team Description

1. **Organizational Chart –** See Attachment.

2. **Current Staff -** See Job Description Attachments – Theresa Burke, VP Children's Services; Imani Seunarine, Plymouth Site Director; CSA Program Directors

3. **Staff to Be Hired –** None.

4. **Roles and Responsibilities –** VP Children's Services will support oversight of the project. Plymouth Site Director will support the implementation of the project. CSA Program Directors will support staff across sites signing up and completing required training. Adapt curriculum so that best practices are shared among all staff regardless of certification. Staff who are participating will complete the modules during the prescribed timeframe and receive certificate.

5. **Project Management –** Weekly conference calls to discuss oversight and progress until fully operationalized. Monthly meetings to discuss implementation, and quarterly meetings to ensure that measures are being met effectively and goals are achieved.

C. Project #5 Implementation Plan and Timeline

.
See Attachment 1- BSCS Project Implementation Timeline

E. Project #5 Sustainability - Information gained from the certification shared with all staff to ensure best practices.

A. Project #6 Description

1. **Project Title – Reflective Supervision Training**

2. **Goal –** Improve the quality of supervision provided to CSA staff resulting in increased staff retention, improved fidelity to the Wraparound model, and better outcomes for families.

3. **Scope –** BSCS and BAMSI will hire a consultant to train program managers and supervisors in Reflective Supervision. Reflective Supervision is a relationship-based practice that expands the idea that supervision is a context for learning and professional development. Through its model of collaboration with and support of clinicians and other providers, Reflective Supervision strengthens the practice of trauma-informed care. Training our CSA Program Managers and Supervisors in the Reflective Supervision model will help to improve staff job satisfaction, improve staff retention, and improve outcomes for families being served by the CSAs.

4. **Deliverables –** One program manager, 2 Program Directors, and 4 program supervisors will be trained in Reflective Supervision during the Prep Period. BSCS staff will report increased job satisfaction and staff turnover rates will improve.

5. **DSRIP Use –** DSRIP funds in the amount of $3,350 will be used during the Prep Period to pay for ½ of the training costs. See Budget Narrative for detail.

6. **Resources –** BSCS will provide existing CSA staff to project team

7. **Funds Allocation –** During the Prep Period, BSCS' program manager, 2 Program Directors, and 4 program supervisors will be trained in Reflective Supervision. The cost will be split between the Coastal and Plymouth CSAs.

8. **Measurement**

Goal: To improve quality of supervision.

a) Specific Measures to Evaluate Impact

   i) Satisfaction of supervisors and supervisees with respect to supervision.
   ii) Staff retention.

b) Timeframe

   i) End of Budget Period 1 - 12/31/18

c) Proposed Goals for Measure

   i) Increase satisfaction with respect to supervision.
   ii) Fifty percent of staff who participate in reflective supervision will be employed for 1 year post.

d) Data Collection

   i) Survey of supervisors and supervisees.
   ii) Staff retention rates.

e) Staff Responsible for Evaluation

   i) VP, Human Resources – Julie Chirillo

B. Project #6 Project Team Description

1. **Organizational Chart –**See Attachment.

2. **Current Staff -** See Job Description Attachments – Theresa Burke, VP Children's Services; Imani Seunarine, Plymouth Site Director; CSA Program Directors

3. **Staff to Be Hired –** None.

4. **Roles and Responsibilities –** VP Children's Services will support oversight of the project. Plymouth Site Director will support the implementation of the project and participate in the training. CSA Program Directors and supervisors will participate in the training and implement the Reflective Supervision Model in the CSA Programs.

5. **Project Management –** Weekly conference calls to discuss oversight and progress until fully operationalized. Monthly meetings to discuss implementation, and quarterly meetings to ensure that measures are being met effectively and goals are achieved.

C. Project #6 Implementation Plan and Timeline

.
See Attachment 1- BSCS Project Implementation Timeline

E. Project #6 Sustainability - Information gained from the training will be shared and incorporated into training new supervisors and shared with all staff to ensure best practices.

A. Project #7 Description

1. **Project Title – Recruitment and Retention Specialist**

2. **Goal –** The goal of this project is to ensure that the BSCS' CSA's employ well trained, diverse and committed staff who have the support and guidance to realize longevity and success in their positions. This project includes funding a Recruitment and Retention Specialist and expenses related to the specialized recruitment needs of the CSA's.

3. **Scope –** BSCS will allocate key staff to coordinate with and support the CSA Recruitment and Retention Specialist in order to create and implement a comprehensive recruitment and staffing plan. This plan will reach out to qualified candidates who reflect the cultures and diversity of the communities that we serve, thus allowing BSCS to increase the number of staff available and thereby increase timely access to CSA services for families. The position will be responsible for posting positions, screening candidates, assisting in orientation and providing ongoing support to CSA staff. This individual will be tasked with increasing the number of staff employed at the CSAs, decreasing the staff turnover rate resulting in timely access to CSA services for families. In addition, the Specialist will be charged with developing and implementing a retention strategic plan in collaboration with the CSA program management and senior level staff.

4. **Deliverables –** Increased number of CSA staff, resulting in a greater number of families served and timely access to care.

5. **DSRIP Use –** Payment of a Recruitment Specialist as follows:

Budget Period	**FTE**	**Amount**
Prep BP	.75 (30 hours)	$16,275
BP 1	.75 (30 hours)	$20,212
BP 2	.75 (30 hours)	$34,650
BP 3	.5 (20 hours)	$23,100
BP 4	.5 (20 hours)	$23,100
	Total	**$117,337**

Additionally, $2,285 will be used for recruiting expenses comprised of $800 for brochures , $1,200 for Linked In Job Posting and $285 for 1 month of job posting on Monster.com.

6. **Resources –** BSCS will commit support to this position from the Human Resources Department specifically the Vice President of Human Resources as well as the CSA and Human Resources teams.

7. **Funds Allocation –** The cost of the Recruitment Specialist will be covered by DSRIP funding through Budget Period 4 and will be evenly distributed between the Plymouth and Coastal CSA programs. See Budget Narrative for detailed information.

8. **Measurement**
Goal: To obtain full staffing levels and reduce staff turnover.

a) Specific Measures to Evaluate Impact

i) Compare actual FTE's to budgeted FTE's.
ii) Staff turnover rates.

b) Timeframe

i) End of Budget Period 2 - 12/31/19
ii) End of Budget Period 4 - 12/31/21

c) Proposed Goals for Measure

i) 90% of budgeted FTE's achieved.
ii) CSA turnover will be less than 25%.

d) Data Collection

i) Staff Vacancy Reports
ii) Staff Turnover Reports

e) Staff Responsible for Evaluation

i) CFO - Marta Reese
ii) VP Human Resources - Julie Chirillo
iii) VP Children's Services – Theresa Burke

B. Project #7 Project Team Description

1. **Organizational Chart –** See Attachment.

2. **Current Staff -** See Job Description Attachments – Julie Chirillo, VP Human Resources; Imani Seunarine, Plymouth Site Director; Janet Daly and Joseph Weeks, CSA Program Directors

3. **Staff to Be Hired –** CSA Recruitment and Retention Specialist

4. **Roles and Responsibilities –** VP Human Resources: Recruit and hire candidate for proposed new position. Provide oversight and job related support to the CSA Recruitment and Retention Specialist throughout the duration of the project. Plymouth Site Director: Coordinate internal resources to effectively implement the project. Facilitate project team meetings and provide monthly written status report to the Senior Management. CSA Program Directors: Participate in project team meetings. Implement recruiting, hiring, and retention plan as outlined in the project plan. CSA Recruitment and Retention Specialist: Coordinate all aspects of the CSAs' Recruiting and Retention activities. Work closely with project team to implement and assess progress.

5. **Project Management –** During Preparation and Budget Period 1, the project team will hold weekly meetings to discuss the project plan and provide updates and report progress toward goals. During Budget Periods 2-3, the project team will meet monthly to discuss progress, track goals, and troubleshoot any barriers to project implementation. During Preparation and Budget Periods 1-3, the project team will generate written reports outlining progress toward goals that will be shared with BSCS' Senior Management.

C. Project #7 Implementation Plan and Timeline

See Attachment 1- BSCS Project Implementation Timeline

E. Project #7 Sustainability - In Budget Period 3 and 4, the Human Resources Department will absorb 10 hours of the CSA Recruitment and Retention Specialist's cost. In Budget Period 5

and forward, the position will be fully integrated into the Human Resources Department ensuring that the recruitment and retention strategies developed and implemented for this project will continue to be a focus of our Human Resources Department.

A. Project #8 Description

1. Project Title – Outreach to Primary Care and Community Providers

2. **Goal -** Increase access to hi-fidelity Wraparound services across catchment areas and increase understanding and education of the benefits of Community Service Agency services to primary care and community providers.

3. **Scope –** In an effort to increase access to Wraparound services, BSCS seeks to use DSRIP funding to enhance understanding, education, and referrals from Primary Care Practices and other Community providers. BSCS will leverage existing relationships with pediatric practices and hospitals across its catchment areas and provide education and marketing to Primary Care Practices and other community providers. As relationships are established, the CSAs will use the Senior Care Coordinators and an identified tenured staff will serve as weekly points of contact for Primary Care Practices to support ease of access for referrals, will share in education/marketing with the Program Director and deploy staff Certified Primary Care Behavioral Health to support families identified. Additionally, BSCS will use an E-referral system (as proposed in Section 6.5) to allow for referrals to be sent over securely and in a timely fashion.

4. **Deliverables –** CSA Program Directors will map out primary care practices in their catchment areas and begin marketing/education campaign about available services to foster strong integration with ACOs and Primary Care Providers. Sr. Care Coordinators and identified tenured staff will provide weekly on-site, telephonic, and electronic consultation and outreach to Community Providers and Primary Care Providers totaling 15 hours per site during the prep budget period and then 8 hours weekly during year 1. Additionally, increased enrollment, and improved and timely access to ICC services will occur.

5. **DSRIP Use –** Salaries for two Senior Care Coordinators and two ICC staff in the amount of $41,152 who will outreach to PCPs and other community providers in an effort to increase access and enrollment, provide education and communication and capture quality measurements from the prep budget period through Year 2.

6. **Resources –** Laptops, computers, cell phones and Internet to access any online/video modules. Use non-producing supervisors for training and curriculum development. Training opportunities can be set up across both CSAs to improve the delivery of services and continuity across the organization.

7. **Funds Allocation –** DSRIP funds in the amount of $41,152 will be used to cover the

salaries during the Prep Period and Years 1and 2 as the Senior Care Coordinators and Staff in each CSA outreach weekly to PCPs and other community providers. Each site will dedicate a total of 15 hours during the prep period and 13 hours in Year 1. Ten hours in total have been allocated in Year 2 for 2 ICC staff to maintain relationships. For detailed calculation see Budget Narrative.

8. Measurement
Goal: To increase referrals from PCP's and other Community Providers.

a) Specific Measures to Evaluate Impact

i) Number of enrolled families.

b) Timeframe

i) End of Budget Period 2 - 12/31/19

c) Proposed Goals for Measure

i) To achieve and/or surpass minimum expectation of 75 enrolled families.

d) Data Collection

i) Claims data showing average number of families served from 1/1/19 to 12/31/19.

e) Staff Responsible for Evaluation

i) CFO - Marta Reese
ii) Third Party Billing Manager – Jennifer Hoffman
iii) CSA Program Directors
iv) VP Children's Services – Theresa Burke

B. Project #8 Project Team Description

1. Organizational Chart –See Attachment.

2. Current Staff - See Job Description Attachments – Theresa Burke, VP Children's Services; Imani Seunarine, Plymouth Site Director; Janet Daly and Joseph Weeks, CSA Program Directors; Deanna McCaffery and Joy Lochelt, Senior Care Coordinators, 2 tenured staff (one from each site respectively)

3. Staff to Be Hired – None.

4. Roles and Responsibilities – VP Children's Services & Plymouth Site Director will provide project oversight. CSA Program Directors will complete a community needs

assessment and liaison for the entire catchment area. Senior Care Coordinators will liaison with pediatric practices and community providers and assign staff to referrals. Staff will support weekly consultation and outreach efforts with Senior Care Coordinators, and begin process of enrollment with families.

5. **Project Management –** Weekly conference calls to discuss oversight and progress until fully operationalized. Monthly meetings to discuss implementation, and quarterly meetings to ensure that measures are being met effectively and goals are achieved.

C. Project #8 Implementation Plan and Timeline

See Attachment 1- BSCS Project Implementation Timeline

E. Project #8 Sustainability - BSCS will lower productivity requirements for supervisors and staff who dedicate time to cultivating relationships that support this initiative. CSA Program Directors will meet with ongoing community members and PCPs to ensure that relationships are strengthened.

6.5 COORDINATION WITH ACOs, MCOs AND PRIMARY CARE PROVIDERS

A. Bidirectional Communication between Bidder and Pediatric Practice – Timely, efficient and authorized communication is critical to achieve best practices in care coordination with ACOs, MCOs and PCPs. Our goal is to develop a bidirectional communication process with all of our referral sources to ensure real time communication. This will be accomplished through the implementation of an email feature that will allow acceptance of E-referrals, enhancement of our EHR and providing on site Care Coordinators.

Our first initiative will be to convert to Microsoft Office 365, which will enable us to send more secure emails and will allow recipients the ability to send documents through a secure upload feature. This secure platform will reduce the back and forth communications and allow for a safe and secure way to send and receive E-referrals for the youth and families.

The second manner in which we will improve bidirectional communication is through our EHR enhancement project. BSCS has been working with eHana in relation to the Behavioral Health-Community Partners (BH-CP) initiative to address the needs of care coordination. The EHR plan for this project will be enhancements of the current documentation to Wraparound-friendly documentation that can be readily shared with all authorized members of the team, as designated by the family. Sharing this information in strength based Wraparound language will support and enhance fidelity to the model.

The final strategy to improve bidirectional communication is to place Senior Care Coordinators in Pediatric Practices. Having a Senior Care Coordinator available to consult with the practice, family, MCOs and ACOs will allow for timely and responsive communication as well as any needed follow up. Being on site will afford the Senior Care Coordinator the visibility and immediate access, once authorized, to critical information needed to support the youth and family. We believe that this "warm hand-off" will increase the PCP understanding and confidence in the ICC service. In addition, the Senior Care Coordinator, as part of the PCP team will be available to respond to potential changes in the youth and family that may be presented to the PCP.

B. Referral Management Protocol for Follow Up and Information Sharing – The implementation of the Office 365 secure E-referral platform described above, will provide the ability to securely communicate and will directly address and improve the security and timeliness of referrals and information sharing with the ACOs, MCOs and PCPs. Once the referral has been received by BSCS, the referral source will receive information on who will be meeting with the family and the contact information for the family's team. During the intake meeting, the CSA staff will obtain a release of information from the family. Based on who the family would like to have access to their care plan, the Care Coordinator will develop a team list consistent with the family's request to ensure follow up and information sharing. The secure email platform will have the capacity to inform the referral source of the family's identified needs and will communicate follow up and plans for developing a care plan.

C. Team Based Treatment Planning – We greatly appreciate the many tasks that the Pediatric Practices accomplish every day to support the well being of their patients. In order to improve

treatment planning collaboration, a Senior Care Coordinator who has been trained in the U-Mass Behavioral Health Integration Training, will be placed on site at the larger Pediatric Practices. Once a Senior Care Coordinator has completed the training, they will be assigned as the liaison to an identified Pediatric Practice. The Senior Care Coordinator will be available to assist the practitioners with behavioral health assessments, consult with practitioners and meet with the family if requested. In placing Senior Care Coordinators in Pediatric Practices, we are confident that we will experience a significant improvement in treatment planning and collaboration with the youth's pediatrician. In speaking to Pediatric Practices, they are very invested in having the Senior Care Coordinator be part of their team so that we are all working together to address the youth's and family's needs.

For those practices that are not able to support a Senior Care Coordinator at their site, the implementation of the email platform that can accept E-referrals will allow for the practitioners to have easy access to the care planning process and will allow for input and recommendations. With the addition of secure email, our CSA staff will be able to send information such as care plans electronically to the PCP in order to elicit meaningful participation from the PCP.

D. Timely Access – We firmly believe that the ability to accept E-referrals will greatly enhance our ability to provide ICC services on a more timely basis. For Program Directors or his or her designee to have referrals electronically, this allows for immediate review and assignment through our e-Hana EHR. As part of this funding we have requested additional laptops and signature pads. Both of these resources will support our ability to respond to and schedule appointments from out of the office.

As previously highlighted, hiring and maintaining our workforce has been our biggest challenge in ensuring timely access to services. As part of this RFR process, we used the SAMSHA workforce development website to identify best practices and innovative strategies. SAMSHA identifies several factors as key components to recruiting and retaining staff including: positive work environments, job satisfaction, professional development, decision making process, manageable workloads and reasonable expectations.

Based on this information, we plan to hire a dedicated Recruiting and Retention Specialist who will refine the agency's Human Resources recruitment and retention strategy. We believe this will enable us to not only recruit, but to maintain quality staff. Professional development and growth is imperative to job satisfaction. Experience and research has clearly demonstrated that when staff has training and certification opportunities, they are more committed and less inclined to leave for other opportunities.

We will offer current staff the opportunity to become certified in Behavioral Health Integration. This will not only increase staff credentials, but will also afford them the ability to increase their responsibility including becoming team members and liaisons to Primary Care Practices. The next step for staff will be certification in Wraparound. For staff who have made a commitment to the service and agency, we will support them in completing this certification. These strategies are designed to maintain and support quality and committed staff.

E. Connections – The BSCS CSAs are fully committed to understanding and responding to the youth and families' experiences related to social determinants of health, including but not limited to: affordable housing, access to education, public safety, and fulfillment of basic needs, as well as availability to emergency services. We recognize that we must have a strong connection to our community to ensure that we have the most up to date information and resources available to our youth and families.

A core component of the CSA staff is to identify natural and community resources that best fit the needs of their family. The CSA team will work with the family to identify supports that have previously been successful and discuss with the family their desire to return or to find new supports. An important lesson that we have learned is that too many resources/referrals can be overwhelming and counterproductive. Careful selection of resources with the youth, family and team will improve connections to social services. In addition, as part of the CSA team we will identify team members that can assist in a warm hand-off.

Our training projects including, Behavioral Health Integration, Certification in Wraparound, Collaborative Training Project and the training resources to be used with our System of Care (SOC), all support increasing the fund of knowledge regarding social services and available resources throughout our communities. We believe by inviting experts to present at the SOC in the topic areas identified by our members, there will be increased participation and commitment to the SOC. Having multiple providers, social services and concerned community members attending the SOC will increase our ability to access and make connections to an array of social services.

In addition, the resources that we will be using to purchase additional laptops will enable us to immediately respond to a family's request for information related to resources. The signature pads will allow us to have a family sign a release which can be electronically submitted to a resource and a discussion can take place immediately.

CSA Budget Report

Behavioral Health Network, Inc. (BHN)

Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites	3	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate	NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)	209	209	209	209	209	209	
Estimated Funds	$ 247,716.00	$ 146,300	$ 87,780	$ 62,700	$ 55,176	$ 25,080	**$ 377,036**
At- Risk Withhold Rate			5%	10%	15%	20%	
Withhold			$ 4,389	$ 6,270	$ 8,276	$ 5,016	**$ 23,951**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 247,716.00	$ 146,300	$ 83,391	$ 56,430	$ 46,900	$ 20,064	**$ 600,800.60**

Investment Projects	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Project 1 Name: Web-Based On-Boarding and Training Development							
DSRIP Goal(s) Addressed: Goal 1:	*Strengthening Fidelity to Wrapraround Processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ 3,080	$ -	$ -	$ -	$ -	$ -	$ 3,080
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ 43,717	$ 36,722	$ -	$ -	$ -	$ -	$ 80,439
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 1 Total	$ 46,797	$ 36,722	$ -	$ -	$ -	$ -	**$ 83,519**
Project 2 Name: *Referral and Triage Workflow Consultation and Improvement*							
DSRIP Goal(s) Addressed: Goal 1:	*Imroving timely access to ICC services for children eligible to receive ICC and their families*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe			$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ 43,971	$ 61,559	$ 2,500	$ 2,500	$ 2,500	$ 2,500	**$ 115,530**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 2 Total	$ 43,971	$ 61,559	$ 2,500	$ 2,500	$ 2,500	$ 2,500	**$ 115,530**
Project 3 Name: *Care Management Software Implementation*							
DSRIP Goal(s) Addressed: Goal 1:	*Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ 43,208	$ 17,283	$ 17,283	$ 17,283	$ 17,283	$ 17,283	**$ 129,623**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ 32,000	$ 18,810	$ 25,080	$ 25,080	$ 25,080	$ 25,080	**$ 151,130**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 3 Total	$ 75,208	$ 36,093	$ 42,363	$ 42,363	$ 42,363	$ 42,363	**$ 280,753**
Project 4 Name: *Provide laptops to all CSA staff*							
Goal 1:	*Fostering Strong integration with ACOs and primary care providers for ICC-Engaged Members*						

DSRIP Goal(s) Addressed:								
	Goal 2:	*Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
	Goal 3:	*Improving timely access to ICC services*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery		$ 56,576	$ -		$ 3,000		$ 3,000	$ 62,576
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 4 Total		$ 56,576	$ -	$ -	$ 3,000	$ -	$ 3,000	$ 62,576

Project 5 Name: *[Project title here]*

DSRIP Goal(s) Addressed:								
	Goal 1:	*Required*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 5 Total		$ -	$ -	$ -	$ -	$ -	$ -	$ -

Project 6 Name: *[Project title here]*

DSRIP Goal(s) Addressed:								
	Goal 1:	*Required*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 6 Total		$ -	$ -	$ -	$ -	$ -	$ -	$ -

Project 7 Name: *[Project title here]*

DSRIP Goal(s) Addressed:								
	Goal 1:	*Required*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 7 Total		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Project Costs		$ 222,552	$ 134,374	$ 44,863	$ 47,863	$ 44,863	$ 47,863	$ 542,378
Indirect Costs/ Administrative Overhead Rate	11%	$ 25,148	$ 15,184	$ 5,070	$ 5,409	$ 5,070	$ 5,409	$ 61,289
Investment Projects Total		$ 247,700	$ 149,558	$ 49,933	$ 53,272	$ 49,933	$ 53,272	$ 603,667

CSA Budget Report - Budget Narrative Prep Budget Period

CSA Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 3 Name: Care Management Software and

DSRIP Project Goal(s):
1 *Strengthening fidelity to Wraparound Processes*
2 *Fostering Strong Integration with ACOs and primary Care Provicers*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Implementation Manager	$ 85,000.00	1	5	$ 35,417
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	1		$ 35,417
	Fringe rate	22.0%	Total Fringe	$ 7,792
			Total IT Staffing including Fringe	$ 43,208

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

The implementation manager will oversee the initial implementation and interface of the care management software with current EMR software. The Implementation Manager will enhance current EHR functionality to prepare for data conversion. The Implementation Manager will train CSA staff in the functionalities of the care management software and create a training guide for both CSA staff and CSA supervisory staff. The care management software will allow CSA staff to be more efficient with tracking tasks for care planning and care coordination activities and track healthcare providers serving ICC-Engaged members. Reports generated by care management software will increase quality of service delivery.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Care Management Software	$32,000.00
Total Technology for Service Delivery	$ 32,000.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Purchase of care management software to interface with current EMR software. Care Management software will provide the ability to run reports on utilization of services, monitor tasks and task completion, and track communication with ACOs and primary care providers. As a result of the software implementation, staff will spend less time on organizing tasks, managing workflows, and documenting cases in order to focus on quality, fidelity, direct care and relationship building with families. Funds from the prep budget period will be used to support the purchase and upkeep of the software during the implementation period through the duration of the project. Funds will also be used through the duration of the project for user licensing fees based on the numbers of end users.
BHN's EHR team and Care Management software team will develop a set of requirements for CSA use of the Care Management software by June 2018. Care Management Software will be installed on each laptop for CSA staff by the end of Budget year 1 and CSA staff will be trained on the use of the software by an IT representative after the software is installed on the laptops. CSA staff and show that they are able to complete the basic tasks with a live demonstration of the skills to their trainer. The system will provide task management functionality, referral management, ability to send information from other sources, and integrate ICC care plan with other care plans. Supervisors will be able to offer clinical support to identify recommendations for care. A care management system will be sought that has client engagement options such a client portal to look up their notes and needs and reminders for upcoming appointments. The software will have reporting functionality and will be evaluated for the ability to gather more comprehensive data on youth goals by having a way to input data from the scaling measures used on the pilot ICP. It will record and remind Care Coordinators of upcoming appointments and be able to run reports on youth/caregiver utilization of ICC services. A decrease in the average length of stay in ICC services is expected if task management and coordination efforts are tracked by the software since CCs will see the intensity of the care coordination efforts they are delivering. This decrease will be evidenced in the CSA state workbooks. Staff will also report increased ease in tracking the collateral contacts required.
Just under 2/3 of the project cost will be supported by BHN BH CP DSRIP funds, just under 1/3 by CCA One Care, and a small amount as noted above in the preparation budget period by CSA DSRIP infrastructure funding.

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name: Laptops for CSA staff

DSRIP Project Goal(s):
1 *Fostering strong integration with ACOs and primary care providers for ICC-Enga*
2 *Strengthening fidelity to Wraparound processes*
3 *Improving timely access to ICC services for children eligible to receive ICC and th*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Laptops	$ 56,576.00
Total Technology for Service Delivery	$ 56,576.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

64 laptops at $884 each will allow CSA staff to access web-based trainings to develop increased skills in understanding the behavioral and medical health needs of ICC-Engaged youth and their families. Laptops will allow CSA staff to access documents while working in the community and in homes. and allow for timely communication with healthcare and community partners to improve integration efforts.

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 1 Name: Web-based Training

DSRIP Project Goal(s):
1 *Strengthening Fidelity to Wraparound Processes, including the care planning, care management, and i*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Web-based computer/screen setup	$ 2,510.00
Labor to mount tv's to wall	$ 570.00
Total Technology for Service Delivery	$ 3,080.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Television, computer and web-cam will be purchased for $2,510 in the Prep Budget Period to provide Ware and Westfield CSA sites with technology needed to do training series as a group. Quote provided by vendor that has equipped other BHN sites with this technology.

Two (2) 50" smart TV's with mounting brackets, two (2) Logitech HD Brio webcams with HD extender, two (2) OptiPlex 3050 mini computers with wireless keyboard and mouse, (2)HD cables = $2510

Labor = $285 x 2 sites = $570.00

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Referral and Triage Workflow

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Workforce Development - Prep Budget Period

Project 3 Name: Care Management Software and

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name: Laptops for CSA staff

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 1 Name: Web-based Training

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Consultant	$ 86,000.00	1	5	$ 35,833
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	1		$ 35,833
	Fringe rate	22.0%	Total Fringe	$ 7,883
			Total Workforce Development Staffing including Fringe	$ 43,717

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

The Consultant will create web-based training program incorporating advanced level trainings on children's behavioral health needs and skill sets for CSA staff that will not be covered by the MassHealth web-based training modules.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Referral and Triage Workflow

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 3 Name: Care Management Software and

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name: Laptops for CSA staff

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 1 Name: Web-based Training

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Referral and Triage Workflow

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Systems Analyst	$ 80,000.00	1	5	$ 33,333.33
Program Director- ICC	$ 65,000.00	0.1	5	$ 2,708.33
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	1.1		$ 36,041.67
	Fringe rate	22.0%	Total Fringe	$ 7,929.17
			Total Program Staffing including Fringe	$ 43,970.83

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

The Systems Analyst will assess the current referral system starting at Central Intake point of entry to determine gaps and needs for youth referred for behavioral health care. The Systems Analyst will look at level of triage for the youth referred (e.g., behavioral health needs, ACOs, primary care providers and other behavioral health services being requested) and make recommendations for a streamlined referral system to improve access to care.

The Program Director of Intensive Care Coordination will oversee CSA implementation activities and guide the efforts of the Systems Analyst and Training Consultant.

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate: $ 25,124.00

Provide a brief description of how the Indirect Cost/Administrative Overhead rate was determined:

To support administrative costs related to general IT, fiscal, and administrative support

Federally approved indirect rate for BHN

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS March 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
3	Care Management Software	Reassign Implementation Manager	01/02/18	02/01/18	**Technology**	IT Staffing including Fringe								
					Technology	Development Adaptation of EHR and/or Care Management System								
4	Laptops for CSA staff	Purchase laptops	01/02/18	03/01/18	**Technology**	Technology for Service Delivery								
3	Care management software	Purchase care management software	12/01/18	06/01/18	**Technology**	Technology for Service Delivery								
1	Web-based on-boarding and training development	Purchase of TV, webcam and processor for web-based training needs	01/02/18	02/01/18	**Technology**	Other Technology Expenses								
1	Web-based on-boarding and training development	Hire Consultant	01/02/18	02/01/18	**Workforce Development**	Workforce Development staffing including Fringe								
					Workforce Development	Recruitment Expenses								
					Workforce Development	Training Expenses								
					Workforce Development	Retention Expenses								
2	Referral and Workflow Consultation and Improvement	Hire systems Analyst	01/02/18	02/01/18	**Operational Infrastructure**	Operation Staffing including Fringe								
		analysis of referral systems	02/01/18	05/01/18	**Operational Infrastructure**	Other Operational Expenses								
					Operational Infrastructure									
					Operational Infrastructure									

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Section 6.2 Executive Summary

Sub-Section 6.2 A

Behavioral Health Network offers CSA services in the Springfield, Robert Van Wart, and Holyoke Service Areas. Our response includes five projects. Each will be implemented in and support all three BHN CSA programs equally. These projects include: 1. Web-based on-boarding and training development 2. Referral and triage workflow consultation and improvement 3. Care management software purchase and implementation
4. Purchase and deployment of laptops for staff.

BHN's Holyoke CSA Development Plan has four goals:

Goal 1. *Training curriculum will be informed by the Wraparound Provider Practice Analysis (WPPA) and seek to continue to build natural supports, community based supports and outcomes based skills:* BHN's 2016 WPPA report showed improvement in 2015 target indicators relevant to decision making and natural supports. During supervision, managers assess fidelity and make recommendations for improvement. They also review Individual Care Plans (ICPs) to measure and evaluate supports and services provided, assess for regularity, and monitor for improvement as needed. Live observations and live coaching of care plan team meetings are completed by supervisors to assess fidelity. Family partners and care coordinators are trained in the use of eco mapping, and social network mapping to help identify clients' natural and community supports.

Goal 2. *Decrease wait time to access ICC services:* BHN is addressing this goal by working to increase the number of qualified staff serving families. Recruiting efforts include job fairs and updated job postings reflective of input from industry experts on best practices in hiring. These efforts have resulted in more qualified applicants. Comprehensive waitlist management efforts include program director reviewing all referrals that come in to the program, follow up calls to the referral sources and/or parent when medical necessity seems unlikely to discuss alternate service options. Supervisors review team progress, medical necessity criteria to monitor the level of care needed, and assessment of transition indicators.

Goal 3. *Enrollment greater than 75:* This goal has been completed through successful hiring of trained staff to serve more families. It took the program greater than one year to hire a qualified supervisor. Inadequate supervisory capacity limits capacity to increase direct care coordinator staffing. We have an ongoing need for better trained staff and greater efficiency serving families. If efficiency can be increased further, greater numbers of youth can be served by the same number staff.

Goal 4. *Increase Child Adolescent Needs and Strengths (CANS) compliance above 80% for initial CANS completed:* This goal will be removed from the plan as it has been met via thorough review of all CANS assessments that were completed but not recorded. Staff received additional reviews and trainings in documentation procedures and completion rates increased to 100%.

BHN's Springfield and Robert Van Wart CSAs share two common goals:

Goal 1. *There will be no youth waiting over the target number of days for ICC and families will be offered an appointment within 3 calendar days of stating interest in ICC.* Current wait time has increased due to an increase in referrals from primary care practices and outpatient therapy. Hiring qualified staff, including bilingual staff, is an ongoing agency effort. Supervisors work with a specific administrative triage staff to determine level of need, call referral sources and/or caregiver to suggest alternative service options if indicated. Training and ongoing communications with BHN Medical Integration Clinicians and Outpatient Therapists about ICC level of care has shown improvements in appropriate referrals.

Goal 2. *A consulting psychiatrist will be determined for the CSA and able to consult as needed.* Goal is completed. BHN Medical Director is the consulting psychiatrist for ICC. The Medical Director in conjunction with other BHN child psychiatry team offer training on clinical presentations and psychotropic medications.

Sub-Section 6.2 B

Strengths: Our CSA programs maintain a strong network of referral sources, community linkages, and collaborations to help enrolled youth receive an array of specific services and supports to meet their care plans goals. Internally BHN is strong in internal collaboration. Youth medical needs are met via integrated primary care behavioral health (PCBH) programs managed by BHN at 11 primary care practices. BHN nurse care managers participate in Care Planning Team (CPT) meetings through BHN Connects! care management service. Our program also has direct access to the BHN One Care nurse, a valuable resource for families utilizing One Care care management services. Our CSA staff attend monthly Department of Public Health (Essential School Health Services) System of Care meetings in Holyoke, as do nurse care managers from Pediatric Associates of Hampden County, one of our PCBH sites. The Springfield CSA System of Care Meeting has representation of the Director of Nursing for the Springfield Public School Department.

Program strengths include two certified Vroon VanDenBerg (VVDB) ICC coaches and one certified VVDB family partner coach, who certify staff in the VVDB Tier One Manual. Long-tenured staff offer a wealth of skill, experience, and organizational memory related to our CSA program. BHN ICC and FS&T program directors have been working in the CSA since ICC services went statewide and have long experience implementing trainings for a large volume of staff with varying learning styles.

Needs: Our needs include expanding our training capacity for all staff; upgrading technology to track the frequency of contact with ICC team members and families, progress towards goals, and ongoing tasks and alerts to upcoming events for enrolled youth; gaining capacity to run reports on enrolled youth and all known providers treating the youth; upgrading to computers customized for running CM software; learning from pediatric medical expertise to support staff with increasing competencies around medical terminology and skill sets; improving our referral management processes and development of work flows for triaging referrals.

Sub-Section 6.2 C

Improving timely access to ICC Services: Over the next 5 years, our DSRIP supported programs will improve timely access to ICC Services. Our innovative ideas for meeting this need include:

1. Enhancing recruitment and retention efforts by offering a wide array of trainings, supervision, technology and supports to new hires and stable employees. Better recruitment and longer retention results in high levels and quality of service provision, and in better access to services. The proposed projects will enable BHN to be the employer of choice in the Western MA CSA world. We will attract and retain the best qualified candidates who will make their work home at BHN, fully equipped and supported to provide the best quality CSA services in the area.
2. Enhancing program efficiencies by making referral and triage workflow improvements. We will develop a uniform process for managing referrals across all three CSAs with scripts for administrative staff triaging calls and flow charts for different levels of service offerings. Scripts will clearly outline medical necessity criteria for ICC services from enrollment to transition as well as clearly define care coordination service components for families.
3. Program directors and supervisors reviewing all referrals on a weekly basis and as requested by administrative staff. A care management system and efficient intake and triage systems will

aid in workflows and task management across the board. A consultant will be hired to assess current flow of referrals from point of entry to assignment and make recommendations for improvement.

Sub-Section 6.2 D

Improving care coordination, care planning, and care management: Care management software will be utilized for functionality related to task management and progress towards goals. Coordination with medical teams will improve with training in common medical conditions and terminology, and PCP consultation on best practices for working with medical providers. During clinical assessment, care coordinators will ask ICC team members scripted questions to control quality of information requests. Questions will support the collection of comprehensive information about enrolled youth to determine how to best address their needs and gaps in service delivery. Supervisors will use scoring tools to measure quality of Comprehensive Assessments and ICPs for consistency across CSAs and for measuring learning/reinforcement needs of the care coordinators.

Sub-Section 6.2 E

Improve performance on quality scores and Development Plan goals: BHN CSAs have piloted a Likert measurement scale of the ICP to better assess progress towards vision, goals and use of natural supports in the care planning process. We anticipate embedding this measurement tool into the care management software, enabling us to ensure consistent utilization of the tool for each ICP developed across all programs. This measurement work will continue to improve fidelity to the wraparound model, help staff review use of natural and community supports at every Care Planning Team meeting, and concretely measure progress of enrolled youth. Web-based training will improve on-boarding and ongoing learning of staff across sites and accommodate their time and pace of learning. Supervisors will have more time to supervise the fidelity to Wraparound through documentation review and live coaching. BHN will evaluate care management software functionality for capacity to populate ongoing tasks, send reminders, and monitor the intensity and duration of service delivery. A consultant will assess our current referral management system to help us clarify areas of need and create protocols and scripts to improve the process of getting youth referred to the appropriate level of care.

Sub-Section 6.2 F

Improving coordination: BHN has longstanding relationships with the majority of pediatric practices in the area. Nurse care managers are integral parts of youth team meetings and partner with BHN staff and families to help address needs and brainstorm service options. This similarity of notions, concepts, and definitions will improve the delineation of unified goals for youth. We intend to partner directly with an increasing number of area providers and assign ICC teams of staff to the youth seen in pediatric primary care practices. This will increase integration and collaboration and result in better outcomes for behavioral and physical health of youth.

Section 6.3 Populations Served and Community Engagement

Sub-Section 6.3 A

Describe member populations and communities

BHN holds three CSA contracts for Springfield, Robert VanWart and Holyoke/Westfield. We serve Agawam, Belchertown, Blandford, Chester, Chicopee, East Longmeadow, Feeding Hills, Granby, Granville, Hampden, Holyoke, Huntington, Ludlow, Longmeadow, Monson, Montgomery, Palmer, Russell, Southampton, South Hadley, Southwick, Springfield, Tolland, Ware, Westfield, and West Springfield. We have offices in Springfield, Westfield, and Ware to enable staff to remain close to the community in which they are assigned. The towns BHN serves are demographically and geographically diverse, and many families experience health inequities. Springfield is the largest CSA BHN serves. Of the 153,060 people living in Springfield, 52% are white, 22 % Black, Latinos of any race make up 39% of the population and 30% live below the FPL. Thirty-nine percent of residents speak a language other than English at home, primarily Spanish. Springfield is a designated health professional shortage area in Mental Health or Primary Care. Asthma rates in Springfield Public Schools are 20% (or 5754), and 41% of students are overweight or obese. BHN enrolled youth and families disproportionately experience health inequities. ICC staff work with area social service providers, state agencies, and medical providers to address unmet family needs.

Ware is part of the VanWart CSA. Of the 9,844 people living in Ware, 51% are female and 49% male. Ware is largely white (96.49%) with .55% Black or African American and 2.08% identified as Latino or Hispanic and 54% of the population is under 45. The median household income $36,870 with 11% living below FPL. Childhood obesity is a significant health challenge in Ware as well, given that 41% of students are overweight or obese. Public transportation is not available in rural Ware. Downtown Ware is designated “slum and blight”, a “food desert” and had the highest rate of death by opiate overdose per capita in 2015 in MA.

Holyoke CSA covers a diverse region of urban (Holyoke), suburban (Westfield) and rural (Huntington, Chester, Granville, Worthington, and Blandford) areas. CSA services are vital to Holyoke residents, a designated health professional shortage area in Mental Health and Primary Care. Lack of healthcare access negatively impacts children’s quality of life. Student asthma rates in Holyoke Public Schools are 23% (or 1,272). Of the 40,124 people living in Holyoke, 48% are White, 48% Hispanic, 3% Black and 1 % Asian. The median income is $36,608, 41% of residents live below the FPL, and 46.9 % of people speak a language other than English at home, primarily Spanish. In the Holyoke CSA, 40% of youth caregivers need services in Spanish, resulting in longer wait times for services resulting in extended length of service time. All enrolled youth need intensive community supports. They generally experience food insecurity, instable housing, inadequate education, poor community connections, English language limitations, or have witnessed/experienced violence. Many need afterschool programming to thrive. Thirty-seven percent of Holyoke students are overweight or obese. The majority of enrolled Holyoke families struggle to meet basic needs and often must decide between purchasing healthful food and paying the rent or utility bill.

Of the people 41,209 living in Westfield, 85% are White, 8% Hispanic, 2% Asian and 2% Black. Sixteen percent speak a language other than English. The refugee population is growing, bringing with it various languages and cultures. The median age is 38, median household income is $45,240, and 11% of the population live below FPL. The majority of enrolled families live at

or below FPL and struggle to meet basic needs. Twenty-four percent of youth are overweight or obese.

BHN will increase training around physical health care needs and engage a medical consultant to support better integration with pediatric practices in order to better promote health and wellbeing of enrolled youth. Partnerships with area pediatric practices and integration into the care planning process will result in better addressing youth medical needs in the ICP. Additionally, a consultant will assess the current flow of referrals from point of entry to assignment and make recommendations for improvement across all three CSAs. Care management software will improve task management and progress towards goals. This should enable youth to move through the wraparound process more effectively. Through these interventions, youth will spend less time waiting. They will begin receiving services that closely meet the intensity of their need, as reflected in the referral, resulting in timely intervention and relief.

Sub-Section 6.3 B

BHN CSAs have spent the last eight years building Systems of Care (SOC) Committees in each respective region to learn about system mandates or changes and to dismantle barriers to accessing resources and services. Through the SOC membership, relationships have been closely formed with the Department of Mental Health (DMH) and Department of Children and Families (DCF). Protocols and point persons are in place with both agencies for service referrals and resolutions to barriers. Both state agencies train ICC staff in their systems and ICC has trained DCF staff on CBHI levels of care. When care planning is not able to move along due to communication or access barriers, we reach out to higher level managers for support. BHN Springfield has close partnerships with the Springfield Public Schools with a special SOC meeting every other month, and with Gandara Center's specialty CSA in Springfield, wherein we discuss the educational and behavioral health needs of youth. BHN ICC has provided training on CBHI level of care to the school nurses in the Springfield Public School District and collaborates with the Director of School Nursing and the Director of Special Education. Holyoke CSA has a long standing relationship with the Westfield schools and has done trainings on CBHI services for the school adjustment counselors and SPED Team Leaders. Holyoke CSA works with Holyoke Public Schools on school driven initiatives to help integrate supports for students with behavioral health needs. The CSA is helping to bridge the gap between school and community for students. Additionally, Holyoke CSA participates on a task force driven by the Hilltown Community Health Center to integrate with other community providers in the rural locations of our service area. Holyoke Health Center is a PCBH site, providing continuity and integration for CSA youth who receive medical services there.

BHN has several large outpatient clinics in the CSA catchment areas as well as the CBHI services of In Home Therapy (IHT), In-Home Behavioral Services (IHBS), Therapeutic Mentoring (TM) and Mobile Crisis Intervention (MCI). All services utilize the same Electronic Health Record, so it is easy to identify which services youth receive throughout the agency. We communicate regularly and supervisors will pull together providers of the various services to resolve conflicts or barriers to team-based planning. Through SOC membership, relationships with external CBHI and outpatient services providers have helped us navigate barriers to serving the youth's care plan needs like referral processes, communication with staff, transitioning to IHT and outpatient levels of care coordination. For youth substance use, the Institute of Health and Recovery trains and consults with our staff on a regular basis.

BHN partners with parent advocacy leagues to offer a monthly support groups to caregivers in Ware, Belchertown, Palmer, Monson and Westfield. Caregivers use the group while receiving

ICC services and after transitioning from the program. They offer valuable feedback on the program. This peer support is vital to youth and family stability.

This section has been modified from the original submission. Updated PBP Budget Narrative reflects changes.

Sub-Section 6.3 C

Through the use of web-based trainings and laptops we will increase access to educational materials and resources. The creation of a web-based training database will allow staff to access the material as needed. Through internal resource sharing, CBHI staff will have access to these trainings as well, resulting in higher quality child and youth services. Increased medical competencies from the training program will help clinicians better understand and address needs identified by school nurses and area pediatric practices. We will build on our partnerships with caregiver agencies, and through our caregiver support groups, we will provide health and wellbeing training topics addressing common need areas identified by the community. With timely completion of care management tasks and timely follow up with CBHI partners, we will be better able to respond to the changing needs of enrolled youth.

Monthly meetings with our CSA and PCBH practices will continue to improve referrals, triage, and access to ICC services. A consulting pediatric nurse from one of these practices will provide staff trainings related to developmental milestones and delays, juvenile diabetes, asthma, nutrition, obesity, and hygiene related issues. The nurse will develop protocols for the care coordinators on how to work effectively with pediatric offices and school nurses. Our partnership with the Department of Public Health, Essential School Health Services, supports consistent collaboration with school nurses.

Section 6.4 Proposed Projects and Investment Plan

BHN has 4projects that will target the goals of

Goal 1: Strong **integration** with ACO and Primary care providers for ICC engaged members
Goal 2: Strengthening **fidelity** to the Wraparound process
Goal 3: Improving timely **access** to ICC services for eligible youth and their families
Goal 4: **Quality** improvement

This section has been modified from the original submission. Updated PBP Budget Narrative reflects changes.

Sub-Section 6.4 A Project 1

1. Name: ***WEB-BASED ON-BOARDING AND TRAINING DEVELOPMENT***
2. Goal 2: fidelity-Easy access web-based onboard and on-going professional development training includes trainings and refreshers in the Wraparound Model
   Goal 4: quality-High model fidelity creates greater quality program
   Goal 4: quality-Uniformity in service delivery

2. and 3. Activities and plans to meet goals: Currently, BHN on-board staff through two days of organizational orientation, overseen by our Professional Development and Human Resources Departments. New CSA staff are then provided with a battery of programmatic orientation by ICC management. High turn-over rates combine with a large amount of training materials to create near continuous on-boarding, consuming an unacceptably large amount of supervisor time. Supervisors spend inadequate time on job functions needed to make our program perform at the highest rates of quality and efficiency, such as attending to the processes for maintaining fidelity to Wraparound.

BHN will strengthen our workforce through improved on-boarding and on-going professional development trainings to staff. This will be achieved through the creation of a web-based training system. Specific training topics may include but are not limited to: systems of care principals and philosophy, The four phases of Wraparound and ten principals of Wraparound, family systems, peer support, partnering with parents/caregivers/guardians, psychotropic medications and their side effects, child and adolescent development, clinical and psychosocial needs, community resources, introduction to child-serving systems and processes, ICPs, safety plans, family driven crisis planning and management, ethnic, cultural and linguistic considerations of the community, mandated reporting, social skills training, basic IEP and special education information, family centered practice, person centered documentation and standards of documentation, and cultural competencies.

Web-based training modules will have competency quizzes at the end of each module that employees must satisfactorily pass. Employees must complete trainings within 12 weeks of employment start date. During the Preparation Budget Period a team will be identified and convened to prioritize topics and develop training modules. BHN will hire a consultant to assist with implementation, and program staff will manage its use in the program over the 5-year DSRIP implementation period. Supervisors will monitor staff completion of the training modules and will also assign staff to review specific trainings during the supervision process when staff would benefit from refresher trainings to help improve performance. Refresher trainings may also be mandated yearly for all staff.

Fidelity to the model will be increased via web-based trainings because all staff will have been trained and quizzed on the topics and supervisors will be allotted more time to work individually with supervisees, either coaching in the field or reviewing documentation and processes, as delineated in the IAP and executed in service delivery. Increased fidelity to Wraparound principals and practices improves client outcomes and a more uniform service delivery across the program. Staff and supervisors who are better and more efficiently trained to perform their duties will be satisfied in their work resulting in long-term retention. This will result in access improvements for youth.

Funds will be used during the preparation period through quarter 4 of FY 18. This new system will be in place and in use through the entirety of the project.

4. Proposed Deliverables
    - Orientation training modules with proficiency measurement tools for new hires
    - Improved use of supervisor time and effort
    - Training compliance tracking package
    - Flexible scheduling to meet staff needs
    - Uniformity in on-boarding communications
    - Meet development plan goals

5. In the Preparation Budget Period, BHN will engage a consultant to create web-based trainings. We estimate 20 hours per week for this consultant. During the Year 1 period we have allocated 2 hours per week for the web-based on-boarding consultant for revisions and modifications to the trainings created.

The preparation period of the project will focus heavily on getting the foundation of the web-based training system implemented. A consultant will begin immediately on evaluating the system for current capacity and will subsequently work with the program directors on prioritizing and scheduling trainings to be put into the system. Year 1 of the project will focus heavily on implementing the new training system, with consultation from the project manager. Years 2-5 will consist of maintenance of the system. Program management will continue to place trainings onto the system for staff use through the duration of the project.

6. Internal Resources: BHN contains a comprehensive network of experts that will be accessed to implement the project including Department of Professional Development staff supplying a Project Manager/Consultant.
    1. Consultant on project and DPD support staff
    2. Go-Sign-Me-Up training platform
    3. Video equipment
    4. Existing curriculum
    5. Supervisory staff to conduct trainings
    6. Subject matter experts
    7. Administrative supports

7. BHN will allocate the funds equally across all CSA site locations for all five projects.

~~8. The training software has capacity to monitor employee compliance, completion of each module and post-training assessment of all assigned trainings. Go-Sign-Me-Up is directly linked to email to facilitate sign-ups, reminders, quiz results and oversight. As training directly related to fidelity, Senior Care Coordinators and Program Directors will use the ICP Review and Comprehensive Assessment Review tools to monitor adherence to Wraparound fidelity measures on these two documents. We know that a well informed Comprehensive Assessment creates better care plans and well written ICPs result in better tracking of outcomes. The results of the~~

~~CA and ICP Review tools will be maintained in a Fidelity Binder to determine and track areas of need for the Care Coordinator's skill development. With an increase in efficiency in training and on-boarding, supervisors will have more time to conduct live coaching of staff. They will use the TOM 2.0 when observing CPT meetings once a quarter and target coaching toward improving scores identified in the observation. We will observe an increase in measurement tool (TOM 2.0) scores; fidelity tools will be seen in live meeting observation of meetings. Especially in areas of natural and community supports and outcomes based Improved scores on ICP and CA reviews will also be evident.~~

~~Through consultation-informed changes in our training process, we will, when entering into the new training protocol, conduct pre- and post- tests on staff for each training series to assess if the trainings are targeting the fidelity indicators as desired. BHN Sr. Care Coordinators and Sr. Family Partners will collect and track the completion of quizzes at the end of web-based training series and review the concepts in supervision. If it appears the concepts are not fully understood, an individualized plan will be created for learning the material. The quizzes will be collected by the Program Directors and tracked in an excel database.~~

~~GoSignMeUp: a web-based application to document attendance, participation and completion of quizzes, will track appropriate renewals for specific trainings. This program will track staff sign up, participation, show acquired competency, completion of training, and audits available. An evaluation will be used to measure satisfaction with the training and meeting goals and objectives of the training. We will modify trainings as needed.~~

8. Web-based training will be accessible to CSA staff to meet the annual mandated training requirements and will improve the wraparound skill sets and increase knowledge in clinical and psychosocial factors impacting youth and families served in ICC. By the end of Prep Budget Period a TV, web cam and processor will be purchased and a consultant will be hired to design and support creation of the web-based training.**Each CC will show an improvement in at least one area of the ICP and CA documentation process and TOM 2.0 scores by the end of Budget Period year 2.**

Training software has capacity to monitor employee compliance, completion of each module and post-training assessment of all assigned trainings. Go-Sign-Me-Up is directly linked to email to facilitate sign-ups, reminders, quiz results and oversight. As training directly related to fidelity, Senior Care Coordinators and Program Directors will use the ICP Review and Comprehensive Assessment Review scoring tools to monitor adherence to Wraparound fidelity measures on these two documents. We know that a well informed Comprehensive Assessment creates better care plans and well written ICPs result in better tracking of outcomes. The results of the CA and ICP Review tools will be maintained in a Fidelity Binder to determine and track areas of need for the Care Coordinator's skill development. With an increase in efficiency in training and on-boarding, supervisors will have more time to conduct live coaching of staff. They will use the TOM 2.0 when observing CPT meetings once every 6 months and target coaching toward improving scores identified in the observation. We will observe an increase in measurement tool (TOM 2.0) scores in at least one need area of each staff previously observed. Especially in areas of natural and community supports and outcomes based measurements. This will be tracked by Senior CCs and CSA PD by comparing previous TOM 2.0 scores. Improved scores on ICP and CA reviews will also be evident from previously scored ICPs and CAs. By the end of Prep Budget period baseline scores on ICPs and CAs within the past 6 months will be

collected by Sr. Care Coordinators and the CSA Program Director. Every 6 months, like the TOM 2.0 observations, CAs and ICPs will be scored with the review tools to show an improvement in previous scores. This will be ongoing as part of the CSA quality assurance process.

Through consultation-informed changes in our training process, we will, when entering into the new training protocol, conduct pre- and post- tests on staff for each training series to assess if the trainings are targeting the fidelity indicators as desired. BHN Sr. Care Coordinators and Sr. Family Partners will collect and track the completion of quizzes at the end of web based training series and review the concepts in supervision. If it appears the concepts are not fully understood, an individualized plan will be created for learning the material. The quizzes will be collected by the Program Directors and tracked in an excel database on an annual basis.

GoSignMeUp: a web-based application to document attendance, participation and completion of quizzes, will track appropriate renewals for specific trainings. This program will track staff sign up, participation, show acquired competency, completion of training, and audits available. An evaluation will be used to measure satisfaction with the training and meeting goals and objectives of the training. We will modify trainings as needed and by end of Budget Period year 2 we will show 100% attendance of all trainings.

This section has been modified from the original submission. Updated PBP Budget Narrative reflects changes.

~~**Sub-Section 6.4 A Project 2 -**~~ **GOAL ELIMINATED DUE TO EOHHS PROVIDING BASIC TRAININGS**

~~1. Name: ***BASIC PEDIATRIC MEDICAL TRAINING***~~

~~2. Goal 1: integration-Increased facility with common pediatric medical conditions and Primary Care/Behavioral Health integration topics~~

~~Goal 1: integration-Improved collaboration with ACOs and PCPs due to staff skill building in community stakeholder collaboration~~

~~Goal 1: integration-Increased understanding of culture of medical practices, language, expectation, structures, work flows~~

~~Goal 4: quality-Best practices in PCP coordination. Physical and BH wellbeing needs are integrated~~

~~2. and 3. Activities and plans to meet goals: Funds will be used during the preparation period to support the pediatric RN. Videos of the trainings will be placed in the training system for use through the duration of the project. A registered nurse with pediatric expertise will provide initial trainings in engagement with PCPs and medical terminology and considerations. The RN will conduct initial trainings for staff on common medical conditions and diagnoses including, but not limited to; asthma, diabetes, epilepsy and obesity, engagement of primary care practices, medical language, psychotropic medication indications and side effects and engagement with primary care providers. The RN will provide consultation and assessment of the training needs of staff and will then create and implement relevant trainings. These trainings will then become part of the web-based training system which will be accessed at any time.~~

~~4. Proposed Deliverables~~

- ~~Protocols in place for integration and coordination~~
- ~~Improved medical culture competence~~
- ~~Training modules with competency measurement tools in place~~
- ~~Improved collaboration with medical system~~

~~5. BHN will hire or assign a pediatric RN (.6 FTE) to work with staff on improving their knowledge of common pediatric issues and terminology. This RN will also work with the web-based training consultant to develop many of the medical trainings on-line. In years 1 and 2, the RN will continue in the program but at a reduced allocation of .3 FTE, and then .15 FTE in year 3. During year 3, the nurse will provide less training and will focus on consultation to program staff regarding engagement with PCPs and medical concerns that require further training and education for staff. At this point, we expect that between web-based medical training and knowledge attained by supervisory and management staff, we will no longer need an RN to maintain this project.~~

~~6. BHN contains a comprehensive network of experts that will be accessed to implement the project.~~

1. ~~DPD support staff~~
2. ~~Nursing staff~~
3. ~~Go-Sign-Me-Up training platform~~
4. ~~Video equipment~~
5. ~~Existing curriculum~~
6. ~~Supervisory staff to conduct trainings~~
7. ~~Subject matter experts~~
8. ~~Administrative supports~~
9. ~~BHN collaborative culture and existing Primary Care Behavioral Health collaborative infrastructure~~
10. ~~Collaboration with BHN Medical Integration Team~~

~~7. BHN will allocate the funds equally across all CSA site locations for all five projects.~~

~~8. GoSignMeUp is a web-based application to document attendance, participation and completion of quizzes. It will track appropriate renewals for specific trainings. This program will track staff sign up, participation, show acquired competency, completion of training, and audits available. An evaluation will be used to measure satisfaction with the training and if training objectives were met. Progress note reviews will show what information is being exchanged with the ACOs including ICPs, discussion of medical concerns and competencies of understanding discussion points. We will communicate with ACO partners using health information exchanges for information sharing We can track communications about client care, behavioral health diagnosis and treatment to the youth's medical providers and managed care organization. Consultations with the nurse care manager will be documented in the youth's record.~~

This section has been modified from the original submission. Updated PBP Budget Narrative reflects changes.

Sub-Section 6.4 A Project ~~3~~ 2

1. Name: ***REFERRAL AND TRIAGE WORKFLOW CONSULTATION AND IMPROVEMENT***

2. Goal 1: integration-PCP or ACO referrals improve; warm handoffs increase appropriateness, timeliness and information sharing
   Goal 3: access-Inappropriate referrals avoided to increase slots for eligible youth enrollees and their families.
   Goal 3: access-Reduce wait times to less than 2 weeks.

2. and 3. Activities and plans to meet goals: BHN will conduct a review of the intake and referral workflow for inefficiencies that lead to repetitive processes and inappropriate referrals, which increase wait times for families to receive services. We will reduce treatment delays caused by incomplete, inaccurate, or missing referral and triage information. Care coordinators will spend less time opening and assessing cases that are then closed due to ineligibility, wasting valuable care coordinator time and program resources. Reducing such churn will provide relief for families who are waiting and appropriate for the service. A Systems Analyst from BHN's Clinical Quality Department will be assigned to design and then evaluate results of this assessment process, as well as to assist in the execution of recommendations that come from the review.

The consultation will identify areas where work is repeated and determine how and why referrals are made that do not meet this level of care. Recommendations will focus on increase the efficiency of the workflow and reduce churn. The project manager will assist in executing recommendations and develop a work plan outlining action steps and timelines.

BHN will reduce treatment delays caused by incomplete, inaccurate or missing referral and triage information. Access to care will increase when recommended improvements are implemented. Additionally, we will increase the intensity of supervision, in-field coaching, and documentation review. We will gain time to use the measurement tools to review documents and increase fidelity to the wraparound model. Staff will have more resources and education to accomplish this goal.

Funds will be used during the preparation period through quarter 4 of FY 18 to support the project manager

4. Proposed Deliverables
   - Scripts for intake and triage staff
   - Efficient workflows
   - Report generated to help assess and manage the wait list
   - Uniform protocols for intake and triage
   - New enrollees and families
   - Effective and accurate communication with families and providers
   - Meet development plan goals

5. During the Preparation Budget period, BHN will allocate a Systems Analyst from our Clinical Quality Department (.6 FTE) to assess the current problematic referral system (e.g., inappropriate referrals, referrals to multiple services, etc.). In Year 1, referral and triage workflow consultation will have resulted in improvement. During this period we will reduce the allocation to .25 FTE as the project should be nearing completion.

6. A comprehensive network of highly skilled BHN employees will implement the project. The Quality Department will provide consultation for fidelity measurement tools.
   1. Department of Professional Development staff-Project Manager/Consultant and DPD support staff
   1. Department of Quality, Quality Analyst position
   2. Administrative supports

3. Subject matter experts
4. Existing workflows to build improvements on
5. Integrated Health Records
6. Connectivity to Interoperable Health Records system via PVIX and MassHiWay
7. Connected Communities Grant holder with 8 community partners
8. Collaboration with BHN Medical Integration Team

7. BHN will allocate the funds equally across all CSA site locations for all five projects.
8. This comprehensive review of referral and triage processes will result in a drop in referrals that do not meet medical necessity at assessment, resulting in less time spent waiting for services to start. A consultant will evaluate the current process and report findings back to the program.

ICC Program Directors will re-write and standardize work flows for managing different level of triage needs across CSAs. We will measure for a decrease in youth waiting for ICC services in the State Workbooks (waitlists). Notes will be logged clearly in the BHN Referral form to record the conversations with the referral source and the caregiver/youth by the administrative staff and the supervisory team so any internal team member can determine the exact status of the referral. With consultation from the Systems Analyst on the Referral and Workflow process, we will see an improvement in the appropriateness of internal referrals as demonstrated and tracked by the number of referrals that meet medical necessity criteria for ICC and the number of referrals made to outside resources if the youth's needs are appropriate for another level of care.

Through a comprehensive referral and triage process review, we will see a shortened wait list. We will measure how long the youth and caregiver stay engaged in services once referred with a minimum of one visit per week over a 6 week period of time.

Administrative staff will track connect-to-care results from point of entry to start of ICC services using state data workbooks.

We will measure a decrease in wait time based on consumer satisfaction, satisfaction with access, and inclusion in the treatment process. The number of people who remain engaged in services after enrollment will increase over time. A Systems Analyst will be hired and an evaluation and analysis of the current referral and triage system completed by the end of the Prep Budget Period. By the end of Budget Period year 2, a triage and referral process will be implemented that ensures youth will triaged for correct level of care and be enrolled within 2 weeks of consent for ICC services.

This section has been modified from the original submission. Updated PBP Budget Narrative reflects changes.

Sub-Section 6.4 A Project ~~4~~ 3

1. Name: ***CARE MANAGEMENT SOFTWARE – PURCHASE AND IMPLEMENTATION***
2. Goal 1: integration and Goal 3: access-Increase referral making efficiency, improve communication and tracking with ACOs and Pediatrics
   Goal 2:fidelity, Goal 3:access, and Goal 4: quality-Care Coordinators increase efficiency and efficacy via electronic task management and alerts to increase numbers served
   Goal 2: fidelity-Increase fidelity via easy access to current and accurate data. Services are delivered as designed across staff, providers, and over time.
   Goal 4: quality-Accurate and efficient reports generated to ensure quality.

2. and 3. Activities and plans to meet goals: BHN is in the process of evaluating care management software that will create more efficient workflows for staff. Project staff will be directly involved in the evaluation, selection and implementation of the software platform in order to choose software that will meet the needs of the program such as: the capacity to populate ongoing tasks, send reminders for upcoming events and monitor the intensity of service delivery. A project manager will be assigned to assist with software evaluation, implementation, staff training, provide on-going support in the early stages of implementation. Staff will spend less time on organizing tasks, managing workflows, and documenting cases in order to focus on quality, fidelity, direct care and relationship building with families.
Funds will be used to support the purchase and upkeep of the software during the implementation period through the duration of the project. Funds will also be used through the duration of the project for user licensing fees based on the numbers of end users.

4. Proposed Deliverables
   - Software in CSA
   - Staff trained in software
   - Effective and accurate communication with families and providers
   - Tracking of collateral contacts, date of service, including ACOs
   - Tracking youth and family contact
   - Task management tools implemented
   - Meet development plan goals

5. Care Management Software – Purchase and Implementation will begin in the Preparation Budget Period. BHN is currently in the process of screening CM software and interviewing potential vendors. We had written 70% of the cost of purchasing this software into our BH CP application, but did not include CSA use in that budget. Based on numbers of clients and the need to customize the product for ICC/FS&T use, we estimate $30,000 for this expense, as well as .4 FTE of an Implementation Manager will be needed. Once the software is in place and we begin to use it in Year 1, there will be PMPM licensing fees based upon the number of clients (not staff) enrolled. Based on our census of 209 individuals served we include $18,810 for this period. We also continue to fund the Implementation Manager at a reduced .15 FTE. The amounts allocated in years 2-5 represent the estimated costs of PMPM user fees for the 209 clients allowed.

6. Department of Professional Development staff-Project Manager/Consultant and DPD support staff
   1. Department of Quality, Quality Analyst position
   2. EHR
   3. IT/IS Department infrastructure and supports
   4. CM Software team researching and implementing project
   5. Submitted BHCP DSRIP grant for software funding
   6. Existing extensive Case Management programming, including ICC, with case management and care coordination expertise and experience
   7. Training protocols and experience to train large numbers of employees on any given topic
   8. Experience implementing new organization-wide software products

7. Allocation of Funds: BHN will allocate the funds equally across all CSA site locations for all five projects.

~~8. Care Management Software will be installed on each laptop (See below). ICC staff will be trained on the use of the software and show that they are able to complete the basic tasks with a live demonstration of the skills to their trainer. The system will provide task management functionality, referral management, ability to send information from other sources, and integrate~~

~~ICC care plan with other care plans. Supervisors will be able to offer clinical support to identify recommendations for care. A care management system will be sought that has client engagement options such a client portal to look up their notes and needs and reminders for upcoming appointments. The software will have reporting functionality and will be evaluated for the ability to gather more comprehensive data on youth goals by having a way to input data from the scaling measures used on the pilot ICP. It will record and remind Care Coordinators of upcoming appointments and be able to run reports on youth/caregiver utilization of ICC services. A decrease in length of stay in ICC services is expected if task management and coordination efforts are tracked by the software. Staff will also report increased ease in tracking the collateral contacts required. ICC Program Directors will run reports on ACOs and PCPs of the youth and track last date of contact the Care Coordinator had with the ACO representative. The software will support with the tracking of the dates of last contact with youth and caregivers as well as team members. Care Coordinators will have access to the reports to track this to determine need for follow up and supervisors will review in supervision.~~

~~A Likert scale on ICPs will be implemented to measure the progress towards ICP vision and goals. The Care Coordinators will be responsible for tracking the changes in scoring from each CPT meeting in the Care Management Software. Supervisors will run reports on client progress and plans in supervision. Higher scores may indicate readiness for transition from ICC services and lower scores or stagnant scores indicate a need for renewed intervention and reworking of the plan.~~

8. Care Management software will be procured by the end of January 2018 using a portion of DSRIP funding. BHN's EHR team and Care Management software team will develop a set of requirements for CSA use of the Care Management software by the end of the prep budget period, June 2018. Care Management Software will be installed on each laptop for CSA staff by the end of Budget year 1 and CSA staff will be trained on the use of the software by an IT representative after the software is installed on the laptops. CSA staff and show that they are able to complete the basic tasks with a live demonstration of the skills to their trainer. The system will provide task management functionality, referral management, ability to send information from other sources, and integrate ICC care plan with other care plans. Supervisors will be able to offer clinical support to identify recommendations for care. A care management system will be sought that has client engagement options such a client portal to look up their notes and needs and reminders for upcoming appointments. The software will have reporting functionality and will be evaluated for the ability to gather more comprehensive data on youth goals by having a way to input data from the scaling measures used on the pilot ICP. It will record and remind Care Coordinators of upcoming appointments and be able to run reports on youth/caregiver utilization of ICC services. A decrease in the average length of stay in ICC services is expected if task management and coordination efforts are tracked by the software since CCs will see the intensity of the care coordination efforts they are delivering. This decrease will be evidenced in the CSA state workbooks. Staff will also report increased ease in tracking the collateral contacts required.

By the end of Budget Period Year 2, ICC Program Directors will run reports on ACOs and PCPs of the youth and track last date of contact the Care Coordinator had with the ACO representative. The data collected will reflect at least once contact by the CC and the PCP/ACO for every youth enrolled in ICC for a minimum of 3 months. The software will

support with the tracking of the dates of last contact with youth and caregivers as well as team members. Care Coordinators will have access to the reports to track this to determine need for follow up and supervisors will review in supervision.
A Likert scale on ICPs will be implemented to measure the progress towards ICP vision and goals. The Care Coordinators will be responsible for tracking the changes in scoring from each CPT meeting in the Care Management Software. Supervisors will run reports on client progress and plans in supervision every 3 months. Higher scores may indicate readiness for transition from ICC services and lower scores or stagnant scores indicate a need for renewed intervention and reworking of the plan.

This section has been modified from the original submission. Updated PBP Budget Narrative reflects changes.

Sub-Section 6.4 A Project 5 ~~4~~

1. Name: ***LAPTOPS***
2. Goal 1: integration-coordinate appointments
   Goal 1: integration and Goal 3: access-respond to email and texts
   Goal 2: fidelity-Staff access care plans and other documents when working in the community and in families' homes
   Goal 1: integration and Goal 3: access-Go-to-meeting access for meetings and collaboration
   Goal 3: access and Goal 4: quality-Staff access resource information in the moment and at the point of care to address presenting needs of clients
   Goal 4: quality-take more accurate case notes soon after intervention while information is fresh

2. and 3. Activities and plans to meet goals: Laptop computers (with air cards (in-kind) for access to internet in community locations) will be purchased and given to staff. These laptops will allow staff to access email, the electronic medical records, care management software, work calendars and the agency intranet containing the web-based training modules. New laptops for all ICC staff will create means for staff to better communicate and utilize needed technology at the point of service in community locations. BHN's IT department will research and purchase the laptops, distribute them to staff members and train on their usage. This will incur a one-time expenditure during the preparation period.

4. Proposed Deliverables
   - Laptop for each staff
   - Technology access in homes and community based locations during interventions
   - Technology access during non-productivity time
   - Increased case loads
   - Timely responses to youth and family needs
   - Timely connections with providers
   - Scheduling efficiencies
   - Meet development plan goals

5. Funds will be allocated in the preparation period for the purchase of 64 laptops for staff. No DSRIP funds will be used after this period on this project. While some staff currently have laptops or notebooks, these are old and inefficient.

6. Internal Resources:
   - IT/IS Department supports and expertise
   - Air Cards for internet connectivity during outreach

7. Allocation of Funds: BHN will allocate the funds equally across all CSA site locations for all five projects.

~~8. Laptops will be purchased, set up and distributed to staff to use in the field. Evidenced by an invoice and an inventory control of which laptops have been assigned to each staff member.~~

8. 64 Laptops will be purchased, set up and distributed to staff to use in the field by BHN IT department by the end of Prep Budget Period. Evidenced by an invoice and an inventory control by IT staff of which laptops have been assigned to each staff member. CSA staff will sign a document that they have received their new laptop as part of the current IT process.

This section has been modified from the original submission. Updated PBP Budget Narrative reflects changes.

Sub-Section 6.4 B

Project Team Description

Sub-Section 6.4 B 2

Current Staff

Michelle Michaelian, Senior Program Manager, Child and Family community based services

- Expertise in management of systems
- Expertise in content area to provide consultation and direction on; training topics, training implementation, coordination of program processes, workflows and triage, outreach to current and potential partners

Alaina Lyon, Program Director Springfield and Van Wart CSA

- Expertise in content area to provide consultation and direction on; Care management software needs, training topics, training implementation, coordination of program processes, workflows and triage, outreach to current and potential partners
- ICC state coach and coaching to senior family partners and staff

Linda Roy, Program Director, Family Support & Training, Springfield, Van Wart and Holyoke/Westfield CSAs

- Expertise in content area to provide consultation and direction on; training topics, training implementation, coordination of program processes, workflows and triage, outreach to current and potential partners
- Coaching to senior family partners and staff
- Family Partner state coach

Ellen Cropanese, Program Director, Holyoke/Westfield CSAs

- Holds expertise in content area to provide consultation on training topics, training implementation, coordination of program processes, workflows and triage, outreach to current and potential partners
- Holds expertise in content area to provide consultation and direction on; Care management software needs, training topics, training implementation, coordination of program processes, workflows and triage, outreach to current and potential partners
- Training and coaching to senior family partners and staff

Anne Beauregard, Systems Analyst, Clinical Quality Department

- Provides consultation on workflows for intake and triage

Sub-Section 6.4 B 3

Staff to engage or hire

A pediatric registered nurse will provide consultation and training to the ICC programs. They will have expertise on collaboration with medical practice and will provide training on medical language and diagnoses (asthma, diabetes, epilepsy etc.), psychotropic medication-indications and side effects.

Web-based training consultant will provide the skills and competencies to work with senior managers to develop a web-based training series that will enhance on-boarding of new staff, as well as annual training to continuing/current staff.

Sub-Section 6.4 B 4

Roles and responsibilities

ICC program directors will collaborate to ensure needs are uniformly met for all staff serving the community. However, each brings expertise regarding the specific needs of their particular communities. As an ICC state coach, Alaina Lyon will provide more direct consultation on fidelity to the wraparound model and person and family-centered documentation. She will be responsible for oversight of the evaluation of the referral and triage processes and will work with the BHN IT and information systems department in the evaluation, selection and implementation of care management software. She also will work in collaboration with Ellen Cropanese to create and implement the web based training system. Ellen Cropanese has focused in recent months on collaborating and coordinating services in local medical practices with our Medical Integration teams, and offers much needed expertise in enhancing communication and collaboration with pediatric care practices. A family partner coach, Linda Roy will provide important perspective on family voice and choice as BHN seeks relevant trainings in the wraparound model.

Our project manager , Anne Beauregard, offers a high-level of proficiency in planning, evaluating and implementing projects related to human service systems. She will provide direction and consultation in choosing and implementing care management software, planning and applying a web-based training system and evaluating current referral and triage practices.

Sub-Section 6.4 B 5

Project management

Project 1.Web-based on-boarding and training development

Ellen Cropanese will be responsible for the oversight of this project. She will serve on the BHN committee to evaluate and select the software and will be the primary manager working on this project. Alaina Lyon will consult and collaborate on this project to ensure the needs of all staff and training requirements are met. Michelle Michaelian will serve as consultant to each manager and as liaison to the executive leadership team and the fiscal department in coordinating the needs of programs for this project.

Project 2. Basic Pediatric Medical Training

Linda Roy will be the manager primarily responsible for this project. She will be the primary contact to all parties and will head the selection committee for the RN to be hired. Linda will coordinate and plan trainings to be held with staff and will facilitate the recording of these trainings to be placed on the web-based system. Linda will collaborate with and receive consultation from Ellen Cropanese and Alaina Lyon in this process. Michelle Michaelian will serve as consultant to each manager and as liaison to the executive leadership team and the fiscal department in coordinating the needs of programs for this project.

Project 3. Referral and triage workflow consultation and improvement
Alaina Lyon will be primarily responsible for the coordination of this project. She will plan and schedule task meetings with the systems analyst to review and evaluate the current workflow, and will then facilitate changes based on the recommendations resulting from the evaluation. Alaina will collaborate and coordinate with Ellen Cropanese and Linda Roy to ensure the new workflow is consistent among all three CSA sites. Michelle Michaelian will serve as consultant to each manager and as liaison to the executive leadership team and the fiscal department in coordinating the needs of programs for this project.
Projects 4. Care Management Software – Purchase and Implementation
Alaina Lyon will be the primary contact for BHN for this project. She will join the internal BHN team that is responsible for the evaluation and selection of the software, and will coordinate the implementation process with Ellen Cropanese and Linda Roy. Michelle Michaelian will serve as liaison to the executive leadership team and the fiscal department in coordinating the needs of programs for this project.
Project 5. Laptops
Each Program Director will be responsible for coordinating with IT and requesting the adequate number of laptops for their respective CSAs.

This section has been modified from the original submission. Updated PBP Budget Narrative reflects changes.

Sub-Section 6.4 C

Sub-Section 6.4 D

CSA Budget Report

Behavioral Health Network, Inc.

Budget	Estimated Members Supported	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Prep Period		$ 208,215						
Budget Year 1	209		$ 65,835					$ 65,835
Budget Year 2	209			$ 62,700				$ 62,700
Budget Year 3	209				$ 37,620			$ 37,620
Budget Year 4	209					$ 25,080		$ 25,080
Budget Year 5	209						$ 12,540	$ 12,540
TOTAL FUNDS								$ 203,775

Budget Allocation	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Workforce Development							
Web-based on-boarding and training development	$ 50,400	$ 3,120	$ -	$ -	$ -	$ -	$ 3,120
Basic Pediatric Medical Training	$ 26,230	$ 21,960	$ 29,280	$ 14,640	$ -	$ -	$ 65,880
Operational Infrastructure							
Referral and Triage workflow consultation and improvement	$ 24,400	$ 10,167	$ -	$ -	$ -	$ -	$ 10,167
Technology							
Care Management software - purchase and annual license fees	$ 30,000	$ 18,810	$ 25,080	$ 25,080	$ 25,080	$ 25,080	$ 119,130
Care Management software implementation manager	$ 20,333	$ 13,725	$ -	$ -	$ -	$ -	$ 13,725
Laptops for all CSA staff	$ 56,576	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL INVESTMENTS							$ 212,022
						Surplus/Loss	$ (8,247)

Attachment C: CSA Budget Narrative

This section has been modified from the original submission. Updated PBP Budget Narrative reflects changes.

Budget Expenses:
Workforce Development **Total:** $145,630

Prep Budget Workforce Development Investments:
Project 1.Web-based On-Boarding and Training Development: BHN will use $50,400 in the Prep Budget Period to engage a consultant to create web-based trainings so that new staff can be more efficiently trained, and continuing staff can receive needed annual trainings. We estimate 20 hours per week for this consultant. This approach will increase ACCESS by training staff in a more efficient way. It will improve QUALITY and FIDELITY by delivering a standardized, uniform, wraparound-informed training to all staff.
Project 2. Basic Pediatric Medical Training. BHN will hire or assign a pediatric RN (.6 FTE) to work with staff on improving their knowledge of common pediatric issues and terminology. This RN will also work with the web-based training consultant to develop many of these trainings on-line. This project will target INTERGRATION by improving staff ability to work collaboratively with health care providers on families' teams, and will improve the overall QUALITY of service provided by staff.

Year 1 Budget Workforce Development Investments:
Project 1. During the Year 1 period we have allocated 2 hours per week for the web-based on-boarding consultant for revisions and modifications to the trainings created.
Project 2. The RN will continue in the program but at a reduced allocation of .3 FTE during this period. Goals as above.

Years 2-5 Budget Workforce Development Investments:
Project 1. Completed.
Project 2. The RN will continue in the program but at a reduced allocation of .3 FTE during year 2 and .15 FTE during year 3. At this point we expect that between web-based medical training and knowledge attained by supervisory and management staff, we will no longer need an RN to maintain this project. Goals as above.

This section has been modified from the original submission. Updated PBP Budget Narrative reflects changes.

Operational Infrastructure **Total:** $34,567

Prep Budget-Operational Infrastructure Investments:
Project 3. Referral and triage workflow consultation and improvement. BHN will allocate systems analyst from our Quality Department (.6 FTE, $24,400) during this periods to assess the current problematic referral system (e.g., inappropriate referrals, referrals to multiple services, etc.). It is believed that by improving our partners' knowledge of how and when to make appropriate referrals and by designing a more streamlined system, we will improve ACCESS to care, and will enhance our INTEGRATION with our medical and other community partners.

Year 1 Budget-Operational Infrastructure Investments:
Project 3. Referral and triage workflow consultation and improvement. During this period we will reduce the allocation to .25 FTE as the project should be nearing completion.

Years 2-5 Budget-Operational Infrastructure Investments:
NA

This section has been modified from the original submission. Updated PBP Budget Narrative reflects changes.

Technology **Total:** $239,764

Prep Budget-Technology Investments:

Project 4. Care Management Software – Purchase and Implementation. BHN is currently in the process of screening CM software and interviewing potential vendors. We had written 70% of the cost of purchasing this software into our BH CP application, but did not include CSA use in that budget. Based on numbers of clients and the need to customize the product for ICC/FS&T use, we estimate $30,000 for this expense, as well as .4 FTE of an Implementation Manager will be needed. Purchasing this software will target all goals: A more efficient workforce will allow for more families to be served, improving ACCESS and INTEGRATION; the software will ensure that agreed upon tasks are tracked, improving QUALITY and FIDELITY; and communication functionality will enhance INTEGRATION with our healthcare and other community partners. Accurate reports generated o increase QUALITY

Project 5. Laptops. BHN will purchase 64 laptops at $884 each for use by CSA staff. While some staff currently have laptops or notebooks, these are old and inefficient. By enabling our staff to access care plans and other documents when working in the community and in families' homes, FIDELITY will increase, QUALITY of care will improve, a more efficient staff should allow for more families to be served and thus increase ACCESS, and electronic in-the-moment communication with healthcare and other community partners will improve INTEGRATION.

Year 1 Budget-Technology Investments:

Project 4 Care Management Software – continued implementation and beginning of user fees. Once the software is in place and we begin to use it, there are PMPM licensing fees based upon the number of clients (not staff) enrolled. Based on our census of 209 individuals served we include $18,810 for this period. We also continue to fund the Implementation Manager at a reduced .15 FTE. Goals as above.

Project 5. Completed.

Years 2-5 Budget-Technology Investments:

Project 4. Care Management Software – license fees. The amounts allocated in years 2-5 represent the estimated costs of PMPM user fees for the 209 clients allowed. Implementation should be complete. Goals as above.

Project 5. Completed.

This section has been modified from the original submission. Updated PBP Budget Narrative reflects changes.

Sub-Section 6.4 E

Project 1. Web-based on-boarding and training. The infrastructure funds will be used to create a series of on-line trainings for new and continuing staff. Because the development of these training videos will occur mostly during the Prep Budget period, with some revisions and additions during the first year budget period, there will not be any sustainability issues on this project.

Project 2. Basic Pediatric Medical Training. The design of this project is such that the pediatric RN that is hired or allocated will work early in the project with the web-based training consultant to create on-line trainings, and then will be available for live family-specific consultation with staff for 2 years. Our hope is that between the on-line videos, and the knowledge gained by supervisory and management level staff, we will then have the internal capacity to continue this training for any new staff, and sustainability will not be an issue on this project.

Project 3. Referral and Triage Workflow. Funds will be used during the Prep Budget Period and Budget Year 1 to conduct this assessment and the redesign of the referral and triage workflow. We expect this project to be completed by the end of this period, and thus sustainability will not be an issue.

Project 4. Care Management Software Purchase and Implementation. Because the purchase and the majority of implementation expenses are one-time costs, sustainability should not be an issue for these expenses. The one cost that will continue is the PMPM fees that the software vendors charge based upon the number of clients enrolled and being care managed with the software. As the infrastructure funding winds down and ends these costs will need to be absorbed by the CSA programs' operating budgets. Although all calculations in this proposal are based upon our historical census of 209 individuals, our hope is that many of the projects detailed here will result in greater efficiencies within the program that allow us to increase our census and serve more families. This growth should lead to an economy of scale that allows for us to fund the CM software PMPM fees after infrastructure support ends.
Project 5. Laptops. This is a one-time expense and should not present any sustainability issues. To the extent that at the end of a 5-year period newer laptops are again needed, they would be supported by the CSA programs' operational budgets, or BHN's annual capital budget.

Section 6.5 Coordination with ACOs, MCOs, and Primary Care Providers

Sub-Section 6.5 A

Bi-directional Communication For over two decades, BHN has been doing business through contracts, joint initiatives, grants and integrated care with the healthcare systems that cover the Springfield, Holyoke and Westfield Service Areas. BHN has applied to become a Behavioral Health Care Partner for the newly established ACOs in Western MA. All of our historical medical partners have been chosen to be an ACO or part of an ACO in our region. BHN partner hospitals are Baystate Health, Sisters of Providence Health Systems, and Holyoke Medical Center.
We also partner with many MCOs: Health New England, BMC Healthnet, MBHP/Beacon, and Commonwealth Care Alliance. For over three years, we have been managing care and fulfilling the CP role in service to 2,000 covered lives for CCA and MBHP. Relationships with healthcare partners have enabled us to be successful in planning, implementing, and problem-solving for a variety of regional integrated and coordinated services. We have a firmly established foundation in collaborating with these entities and will continue to do so within our CSAs in order to maximize care for the youth and families we serve.
We also have built significant collaboration internally with our Integrated Care program. CSA staff meet with key integration staff who are responsible for youth interventions in the integrated pediatric practices. Improvements to this new model include weekly or monthly meetings, depending on the need. They provide low-level problem solving in real time, negating the need for a higher level of problem solving and conflict resolution. Our collaborative service delivery model will build in processes for good dialogue and team approaches to delivery so that our program staff may successfully manage many issues before they become problems. We will use these internal relationships to leverage greater access and collaboration with pediatric practice medical staff.
Current community health center and Federally Qualified Health Center pediatric partners include High Street Health Center-pediatrics, Holyoke Health Center and Caring Health Center. We have been integrating clinicians, CSP workers and care managers into these setting for many years. Group and primary care practice integration includes Holyoke Pediatric Associates, Pediatric Care Associates, Mercy Medical Practices, Pediatric Associates of Hampden County, Family Medicine Associates, and Valley Medical Associates. Our embedded staff includes

master's level clinicians, community support workers, care managers (for One Care and MBHP Provider-based CM), peers, family partners, and recovery coaches.
A care coordinator will be joining the two family partners who are already established at the Holyoke Health Center to team with BHN's medical integration team and the PCPs to support further integration of behavioral health and physical care. Holyoke teams with nurse care managers out of Pediatric Associates of Hampden County, coming to CPT meetings representing the complex physical needs of youth and integrating the behavioral needs back into the pediatricians practice.

Sub-Section 6.5 B

Referral management protocols

Currently, when a youth is referred by an integrated medical practice, an ACO or pediatric office, the referral is currently tracked via a BHN referral form. BHN Central Intake personnel enters the referral into the system and then CSA administrative staff typically spend a significant amount of follow up time gathering information missing from the intake process. Staff then contact the caregiver/youth to describe ICC services in detail. We frequently have problems contacting the caregiver/youth, and our staff must inform the referring organization of barriers met in engaging the client family, another significant time consuming process. After the initial contact is made, we inform the referral source of the caregiver/youth treatment status, either if the client refuses services or the enrollment date. At enrollment, we obtain signed consent for authorization to release information to the ACO or pediatric office. Once these administrative steps have been taken, the care coordinator then calls the ACO/pediatric office to explain the ICC process and then sends a letter and authorization to the ACO or pediatric office for ongoing communications.
When the youth does not meet Medical Necessity Criteria, the care coordinator sends the referring agency a copy of the Comprehensive Assessment, CANS and as well as an ongoing support plan outlining the recommendations for more appropriate services with contact information for any referrals made for the youth and family. Even when a youth is not appropriate for ICC services, we will still make referrals to other types of services.
Much work is ahead of BHN to improve our referral management protocols to reduce the time spent on and number of inappropriate referrals as well as to increase the number of referrals from practices which currently underutilize CSA services. We intend to review our process with a professional systems analyst, which will enable us to better understand the weaknesses of our current system and make systematic improvements to it.

Sub-Section 6.5 C

Treatment Planning BHN has integrated with Holyoke Health Center, assigning specific ICC staff to HHC staff for continuity and integration between the two programs. CPT meetings are held at HHC and representatives from Medical Integration will meet with the family and team to participate in the planning process. When pediatric staff cannot participate, we reach out to the medical provider to explain the importance of the pediatrician's role in the youth's overall wellbeing and to share mutual expectations for coordination. The care coordinator asks for the physician's perspective on the youth's needs and how physical health may impact mental health and then share our assessment of behavioral health needs. The care coordinator includes physical needs into the care planning process and follows up with the PCP/ACO on progress towards goals, options chosen and tasks assigned. Manually tracking calls, activities, and needed follow up is a very labor intensive process. Implementing better technology and relationship building

across silos will improve collaboration and timely PCP/ACO access to records, while increasing ICC staff efficiency.

Sub-Section 6.5 D

Access A consultant will evaluate the current intake and triage processes to find inefficiencies in our model and make recommendations for improving work flow. ACOs and PCPs will be identified at intake so we can track referrals accordingly. The consultant will help to create scripts and review trends in referrals. We will continue to reach out to ACOs and pediatric offices about appropriate kinds of referrals and provide educational materials. Family partners and care coordinators will be stationed at pediatric offices to assist with recommending appropriate levels of care.

Sub-Section 6.5 E

Connection to Social Services Care coordinators and family partners keep each other well informed of resources in our communities. They are able to quickly assess needs and make recommendations for community based services and suggest ways the caregiver/youth may engage the service. We will continue to use our connections with the Family Resource Centers in Springfield and Amherst. We will develop a connection with the newly forming Family Resource Center in Holyoke to bridge families to the free resources like ESL classes, budgeting, job search, school advocacy, Child Requiring Assistance applications, food pantry, parent groups and health awareness topics. Springfield, Robert Van Wart and Holyoke will continue to bring new representatives to our SOC meetings to share opportunities for caregivers. Many referrals are made to ICC due the caregiver requiring help with housing, transportation, and their own mental health needs so the youth can access behavioral health care. When youth do not meet the ICC level of care, Family Resource Centers may also offer a caseworker to get families connected with appropriate services.

In the rural Hilltowns covered by the Holyoke CSA, families are isolated from many services and supports offered in the larger cities. As a result, we have formed partnerships with the Hilltown Health Center to access child care, food banks, and domestic violence supports and services. We have also partnered with various parent advocacy programs like PPAL and Family Support Network to bring parent support groups and trainings to our Westfield and Ware regions. We have experience collaborating with community partners like Jewish Family Services and Ascentria Care Alliance, organizations that work specifically with refugee and immigrant populations to address cultural barriers to engaging and accessing services. We bring in rotating presenters on different social topics that impact our communities served so care coordinators and family partners are up to date on resources in their communities. Web-based training modules related to community resources and the introduction to child-serving systems will enable our staff to gain and maintain a thorough understanding of the community resources available to the youth and families BHN CSA serves. When our staff know who is working on the important needs of the community, we are well equipped to effectively to join in building larger community and systems collaborations, as demonstrated in our CSA program to date.

CSA Budget Report

The Brien Center

Investment Funding		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites		1	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate		NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)		145	145	145	145	145	145	
Estimated Funds		$ 106,980.00	$ 101,500	$ 60,900	$ 43,500	$ 38,280	$ 17,400	**$ 368,560**
At- Risk Withhold Rate				5%	10%	15%	20%	
Withhold				$ 3,045	$ 4,350	$ 5,742	$ 3,480	**$ 16,617**
TOTAL MAXIMUM FUNDS AVAILABLE		$ 106,980.00	$ 101,500	$ 57,855	$ 39,150	$ 32,538	$ 13,920	**$ 351,943.00**
Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Project 1 Name: Enhance Intensive Care Coordination & Pediatric Integration								
DSRIP Goal(s) Addressed:	Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
	Goal 2:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ 51,000	$ 27,000	$ 28,000	$ 26,000	$ 26,000	$ 26,000	**$ 184,000**
Technology for Service Delivery		$ 18,000	$ 8,424	$ 17,280	$ 17,280	$ 17,280	$ 17,280	**$ 95,544**
Other Technology Expenses		$ 6,000	$ 3,000	$ 1,500	$ 1,500	$ 1,500	$ 1,500	**$ 15,000**
Workforce Development								
Workforce Development staffing including Fringe								**$ -**
Recruitment Expenses								**$ -**
Training Expenses		$ 3,600	$ -	$ -	$ 2,400	$ -	$ 2,400	**$ 8,400**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure								
Operation Staffing including Fringe		$ 8,176	$ 8,203					**$ 16,379**
Other Operational Expenses		$ 1,250	$ 5,700	$ 6,350	$ 6,350	$ 6,350	$ 6,350	**$ 32,350**
Project 1 Total		$ 88,026	$ 52,327	$ 53,130	$ 53,530	$ 51,130	$ 53,530	**$ 351,673**
Increase ICC Workforce Capacity								
DSRIP Goal(s) Addressed:	Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
	Goal 2:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development								
Workforce Development staffing including Fringe								**$ -**
Recruitment Expenses		$ 1,500	$ 1,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000	**$ 6,500**
Training Expenses		$ -	$ 5,265		$ 1,755		$ 1,755	**$ 8,775**
Retention Expenses								**$ -**
Operational Infrastructure								
Operation Staffing including Fringe								**$ -**
Other Operational Expenses		$ 3,500	$ 1,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000	**$ 8,500**
Project 2 Total		$ 5,000	$ 7,265	$ 2,000	$ 3,755	$ 2,000	$ 3,755	**$ 23,775**
Total Project Costs		$ 93,026	$ 59,592	$ 55,130	$ 57,285	$ 53,130	$ 57,285	**$ 375,448**
Indirect Costs/ Administrative Overhead Rate	15%	$ 13,954	$ 8,939	$ 8,270	$ 8,593	$ 7,970	$ 8,593	**$ 56,317**
Investment Projects Total		$ 106,980	$ 68,531	$ 63,400	$ 65,878	$ 61,100	$ 65,878	**$ 431,765**

CSA Budget Report - Budget Narrative Prep Budget Period

CSA Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name:Enhance Intensive Care Coordination & Pediatric Integration

DSRIP Project Goal(s): 1 *(1) Fostering strong integration with ACOs and primary care providers for ICC Enr*, 2 *(3) Improving timely access to ICC services for children eligible to receive ICC and* 3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Acquisition and implementation of etrana CSA electronic health record module	$ 51,000.00
Total Development and Adaptation of EHR and Care Management System	$ 51,000.00

acquisition and etrana implementation of CSA EHR module, licenses for MassHiway integration, CANS interoperability , integration with AR+ billing system

CSA module project implementation $28,000
etrana EHR -upfront costs inclusive of billing integration $11,000
etrana EHR licensing $2,000 / months 4 months $8,000

The etrana CSA module is completely separately separate from the etrana care management platform being use by the BH-CP

Technology for Service Delivery

Description of Expense	Cost
Laptops	$ 8,330.00
Smartphones	$ 2,700.00
Data service for phones	$ 3,600.00
Data air cards	$ 3,600.00
Total Technology for Service Delivery	$ 18,000.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Laptops 18@$450
Smart phones 18 @$150
Data service for smart phone s 18 @ $40/ month x 5 months
Air cards for remote Wi-Fi access 18 @ $40/ y r. 5 months

18 FTE represents the number of ICC clinical and supervisory staff

These will enable ICC workers to effectively work in the community, have remote access to email and messaging as well as access electronic health record and ACO resources.

Other Technology Expenses

Description of Expense	Cost
Networks interface/ systems issues	$ 6,000.00
Total Other Technology Expenses	$ 6,000.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Estimate of costs associated with data integration and transition from current I-Centrix server based MSOP EHR to etrana web based CSA EHR module including interface with existing EHR and billing system, EHR provider set ups: 24 hours @$250/ hour. Transition will accommodate the CSA data, billing and messaging requirements)

Project 2 Name: Increase ICC workforce ca.

DSRIP Project Goal(s): 1 *(2) Strengthening fidelity to Wraparound processes, including the core planning,* 2 *(3) Improving timely access to ICC services for children eligible to receive ICC an* 3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

DSRIP Project Goal(s): 1 *Required* 2 *Optional* 3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

DSRIP Project Goal(s): 1 *Required* 2 *Optional* 3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

DSRIP Project Goal(s): 1 *Required* 2 *Optional* 3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

DSRIP Project Goal(s): 1 *Required* 2 *Optional* 3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

DSRIP Project Goal(s): 1 *Required* 2 *Optional* 3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Workforce Development - Prep Budget Period

Project 1 Name:Enhance Intensive Care Coordination & Pediatric Integration

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
UMass primary care integration training certificate training	$ 3,600.00
Total Training Expenses	$ 3,600.00

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

UMass Medical primary care/ pediatric care integration certificate program for program director and 2 supervisors @ $1200 each

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Increase ICC workforce ca.

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate				$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
recruitment of ICC staff using Indeed, newspaper and other mechanisms	$ 1,500.00
Total Recruitment Expenses	$ 1,500.00

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

recruitment to fill difficult to fill ICC staff using Indeed, newspaper advertising , local job boards, professional placement listings

Estimate is based on Indeed listing $500, newspaper advertising $750 for newspapers in Great Barrington, Pittsfield and North Adams; $250 for professional job listing sites

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 1 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Program Manager	$ 48,300.00	0.125	6	$ 3,019
Program Supervisor	$ 36,250.00	0.125	6	$ 2,266
Support staff	$ 28,500.00	0.125	6	$ 1,781
				$ -
				$ -
Total Salary		0.375		$ 7,066
Fringe rate		19.17%	Total Fringe	$ 1,111
			Total Program Staffing including Fringe	$ 8,176

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Program Director oversees the ICC program and this project. During prep period, will be planning out the implementation of the proposal, coordinating training programs, enhancing relationships with primary care and the ACO.

Program supervisor supports and coordinates ICC staff and family partners . During prep period this position will be involved in planning support and family focus groups, improving communications with primary care and assisting staff through program transition

Support staff will assist with planning, material preparation and coordinating communication .

These positions are specifically for CSA and not BH-CP and are currently funded by revenue from CSA billing. The portion being allocated to this project will not be available for generating third party income.

Other Operational Expenses

Description of Expense	Cost
Development of client and primary care education material	$ 1,250.00
Total Other Operational Expenses	$ 1,250.00

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Development of information flyers in English and Spanish including translation, $500. Printing of 2,000 color flyers at .35= $750. = $1250

In future periods it is planned to have mini provider lunch conferences on relevant topics and consumer/community focus groups.

Project 2 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Technical consulting	$ 3,500.00
Total Other Operational Expenses	$ 3,500.00

Technical consulting on replacing current billable hour based productivity incentive to a new method that is relevant to the change in ICC payment structure. Source is TBD. Estimate 14 hours @ $250./ hour Estimate of rate is based on comparable specialist consultants , estimate of hours assumes learning current process, evaluating alternative based on changes in ICC contract , developing new model and assisting with developing a process to collect necessary data .

Project 3 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate: 15.00%

Provide a brief description of how the indirect Cost/Administrative Overhead rate was determined.

Indirect cost percentage as of 9/30/17

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	Investment Project Name	Implementation Goal	Goal Start Date	Anticipated Goal End Date	Investment Category	Investment line Item within Category	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
1	**Enhance Intensive Care Coordination & Pediatric Integration**	Acquire laptops and other technology and set up data plans for ICC staff	12/01/17	01/31/18	**Technology**	Technology for Service Delivery	first phase of technology is operational	staff are utilizing technology						
1	**Enhance Intensive Care Coordination & Pediatric Integration**	Develop plan and schedule for provider conferences and focus groups.	01/01/18	05/31/18	**Operational Infrastructure**	Operation Staffing including Fringe	preliminary plan	documentation of efforts						
	Enhance Intensive Care Coordination & Pediatric Integration	Staff are enrolled in Umass Intergrated primary care training	01/01/18	12/31/18	**Workforce Development**	Training Expenses	at least 2 individuals have enrolled	records of enrollment						
2	**Increase workforce capacity**	Development of staff incentive program	01/01/18	05/31/18	**Operational Infrastructure**	Other Operational Expenses	plan is completed for implementation	plan is implemented						
2	**Increase workforce capacity**	Development and Implementaion of recruitment plan	01/01/18	05/31/18	**Workforce Development**	Recruitment Expenses	Recruitment efforts have been implemented	documentation of efforts						

Section 6.2 Executive Summary

Historically, managed care has not evolved significantly in this region, many partnerships have formed over multiple decades, in large part due to geographic isolation in the Berkshires. The Brien Center knows that collaboration is essential to survival in this area, and improved integration between pediatric offices and the Brien Center is vital.

The Brien Center has very strong, collaborative relationships with the recently selected Medicaid ACO Partner, the Health Collaborative of the Berkshires, LLC (HCB). HCB consists of Berkshire Health System and Community Health Partners (CHP), the two largest primary care organizations in the area. HCB is currently negotiating an ACO Contract with EOHHS. HCB and CHP work very closely with the Brien Center, and the strength of our relationships guarantee successful outcomes from the proposed CSA infrastructure projects.

A. Current Performance on Development Plan

The Brien Center, Berkshire County's largest community Behavioral Health agency, has a long history of providing high quality, comprehensive community-based services to youth under the age of 21 with Serious Emotional Disturbance. The Brien Center has demonstrated strong performance to date on the Development Plan. In the last several months, The Brien Center reported multiple successes to the Executive Office of Health and Human Services (EOHHS) that include, but are not limited to:

- Continuing to eliminate waitlist with eight waitlist free months and faster access to care
- Ongoing ability to maintain timely referral assignments to Intensive Care Coordinators (ICCs)
- Hiring and retaining new ICC staff

Of the seven individual initiatives included in the current Development Plan, The Brien Center completed six of the Development Plan's specific tasks, which are as follows:

- Include monitoring/tracking of diagnoses and medications in regular internal audits.
- Utilize regular psychiatric training/consultations to offer psychoeducation on the best ways to locate current, accurate information in electronic medical systems.
- Enhance technical training curricula to focus on family voice, rehearsal, rituals, and celebration of small successes throughout the course of ICC services. Explore and discuss creative options for discharge celebrations/ceremonies with families and youth.
- Introduce and incorporate evidence-based tools for ICCs into Care Planning protocols.
- Continue providing technical assistance to new office manager regarding the various data collection and reporting processes required by the CSA.
- Regularly review communication processes among team members and data manager, with emphasis on ensuring timely communication from ICCs and Family Partners; consistency among data recorded in various tracking systems; and, elimination of confusing steps in the process.

EOHHS received progress reports in March 2017. Brief, current progress reports on these projects since March 2017 follow:

Project	Progress Update
More training regarding "golden thread" and accurate reporting of current medication.	Since April 2017, all group staff meetings have included training on conducting quality-driven assessments, including efforts to gather more comprehensive information. Our work has led to better identification of consumer needs and goals. We have also trained staff to incorporate the youth's diagnosis and current treatments into the Discovery Process.
Ensure that documented efforts of transition planning are evident during chart audits.	We have seen improvements in this area when completing monthly chart audits. We also have provided refreshers about utilization of our Transition Readiness Scale, and key components of purposeful transition.
Develop and implement the practice of training and assisting families in their progressive development of team meeting leadership skills. When appropriate, incorporate family-led team meetings as a measure of transition-readiness.	We have achieved more frequent conversations with families about purposeful transition processes. We are also creating a mechanism for tracking the frequency of family-led meetings.

B. Examples of Strengths and Needs

Strengths

The Brien Center's CSA program meets and exceeds most of the State's CSA program standards. Examples of The Brien Center's CSA program strengths include:

- Strong collaboration with existing community programs, services, and providers throughout Berkshire County.
- Positive scores on quality measures that illustrate fidelity to the Wraparound Model. For example, our CSA scored above both the State and national average on overall Team Observation Measures, and above State and national averages on five of six Key Elements based on the Wraparound Fidelity Index (WFI). We have scored higher than the State average for Overall Fidelity since 2012, and on the WFI since 2014.
- Positive outcomes for youth/families served. Since January 2016, 61% of enrolled youth met their goals and graduated from Wraparound services. Also in 2016, 97.3% of families reported that they felt better able to respond to their child's needs and that they gained knowledge about their child's needs.
- The ability to engage families and "meet them where they are." The Brien Center brings youth and families' voices to the forefront in our Discovery and Individual Action Plan development processes. The most recent Massachusetts Practice Review, conducted in 2016, showed that The Brien Center's average score for the "Family Driven & Youth Guided" element was above the State's average.

Needs/Opportunities for Improvement

The Brien Center sees each identified need as an opportunity to improve the services we deliver to youth and their families. Key needs or opportunities for improvement include, but are not limited to:

- Recruitment and retention of ICC and other staff. Recruitment and retention in the State is difficult, but even more challenging in the Berkshires, given our service area's rural nature. The Brien Center plans to apply for Delivery System Reform Incentive Payment (DSRIP) investment funds to strengthen our ability to both recruit and retain staff.
- The ability to ensure fidelity to the Wraparound model. The Brien Center request infrastructure funds to increase fidelity to the Wraparound model by training senior staff who will then train additional ICC staff in-house.
- Enhancing our connections with Community-Based Organizations (CBOs) and, of creatively identifying additional resources to meet needs.

C. Plans for Improving Timely Access to ICC Services

Today, the Brien Center is fully staffed and offer access to ICC Services within 10 business days. If necessary, we will improve access to ICC services by recruiting and retaining staff as needed. The Brien Center will also apply for DSRIP funds to enhance staff recruitment and retention.

D. Plans for Improving Care Coordination, Care Planning, and Care Management for ICC-Engaged Members

The Brien Center's two requests for Infrastructure and Capacity Building Funding both seek to enhance care coordination, care planning, and care management for ICC-Engaged Members.

First, we plan to conduct ICC Team meetings, when appropriate, in pediatrician's offices, with greater engagement of, and support for, youth, families, and providers. Second, our request for funding to procure expert training in the Wraparound Model and Systems of Care philosophy will further enhance fidelity to the model and will increase coordination, planning, and care management for ICC-Engaged Members.

E. Plans to Improve Performance on Quality Scores and Development Plan Goals

The Brien Center measures structures, processes, and outcomes of care on an ongoing basis. For the CSA, our plan is to develop specific metrics to evaluate: fidelity to the Wraparound Model; improvements in ICC-Engaged Member satisfaction; and, to create other Population Health measures that allow The Brien Center staff to assess and improve performance. In addition, we will continue to meet Development Plan Goals and hope to align our goals with efforts described under this RFR submission.

F. Plans for Improving Coordination with Providers Across the Care Continuum for Youth

The Brien Center's proposed practice-based ICC model maximizes coordination with pediatricians (and other providers) through on-site Care Management meetings in the pediatrician's office. Such meetings may also include other providers, State agencies, family, and CBOs. Through this project, we will improve coordination with providers, as well as CBOs, State agencies, and other stakeholders across the full care continuum.

Section 6.3 Populations Served and Community Engagement

A. Experience with Populations and Community Engagement Strategy

Member Populations and Communities Served

The Brien Center, Berkshire County's largest community Behavioral Health (BH) agency, has a long history of providing high-quality, comprehensive community-based services to youth under the age of 21 with Serious Emotional Disturbance (SED) whose impairments substantially interfere with the youth's ability to function within their family, school, and/or community activities. The Brien Center serves youth who experience trauma, often severe; anxiety disorders; significant learning issues; severe disturbances in interpersonal relationships with peers and teachers; inappropriate behavior, often dangerous or extreme; and oppositional and attention deficit disorders. The Brien Center is highly familiar with each of these issues and treats youths with such symptoms as a CSA in Berkshire County through our Intensive Care Coordination (ICC) program. The Brien Center also serves transitional age youth and adults with Serious Mental Illness and Substance Use Disorders.

Experience and Community Engagement

Our mission is to promote the greatest degree of recovery, independence and quality of life for the youth and families we serve by delivering integrated BH and community-based services with a significant emphasis on integration of primary care. We provide access and supports to meet the BH needs of youth and adults of all ages, race and cultures, and intellects, enabling them to live healthy lives in our community. As part of our approach, we collaborate with State agencies, individuals, families, and other providers to promote a holistic, person-centered approach.

The Brien Center's host of programs—which include the Children's Behavioral Health Initiative, Outpatient Programs, Community-Based Acute Treatment, Therapeutic Day Services, The Continuum, STAY Program, and the Community-Based Flexible Supports Program as well as our CSA designation—offer EOHHS solid credentials to support The Brien Center's participation as a Delivery System Reform Incentive Payment-funded CSA. Our current and active participation in the CSA programs illustrates our ability to care for youth and families with SED. As a CSA, we successfully engage youth and families under the Youth's Behavioral Health Initiative.

At The Brien Center, one of our key objectives is to facilitate the health and well-being of the families we serve. For example, some of our strategies to engage families and youth include actively involving families and youth in the treatment process; delivering culturally and linguistically competent care; employing trained staff who value recovery and wellness as guiding principles of care delivery; and, whenever possible, using evidence-based practices to support care delivery methods and practices.

The Brien Center recognizes the importance of Community-Based Organizations (CBOs) as an integral component of our treatment approach. The Brien Center works closely with Berkshire

Children and Families (BCF) to provide intensive services to youth with serious emotional disorders, including a subcontract with BCF to provide Family Partners for our CSA. BCF subcontractors provide a full-time clinician for their Family Resource Center. In addition, The Brien Center provides group home services for our Continuum under contract with the Key Program. We provide substance prevention programs, among other services to youth, in collaboration with Northern Berkshire Community Coalition; gang prevention services in collaboration with the Pittsfield Community Connection; and substance abuse prevention and outreach through the Berkshire County school system.

The Brien Center has built trusting, collaborative relationships with the youth and families we serve over the past 40 years. Our staff connects with hard-to-reach individuals including those who are homeless, sheltered, and others whose families struggle with alcohol and/or opiate addiction and/or misuse. We help youth and families achieve recovery and wellness goals through our outreach and engagement expertise, helping youth remain in the communities in which they live and work.

Regions or Service Areas Covered: The Brien Center serves consumers in the Pittsfield and Adams service areas, which encompasses all of Berkshire County.

Plans to Promote the Health and Wellbeing of Individuals Served

The Brien Center subscribes to a Systems of Care philosophy to locate, outreach, and engage ICC-Eligible youths and their families, partnering with families, caregivers, and youths in service planning and delivery. We begin with a holistic, culturally and linguistically appropriate Discovery Process that fully engages the family and/or caregivers. By first building rapport and trust, we increase our ability to connect youth and their families in a manner that communicates a sense of safety and acceptance.

The Brien Center meets potential Enrollees at locations in the community where the youth and families are comfortable, which may include but not be limited to their home, school, or their Primary Care Provider's office. We seek to genuinely connect and build trust with the youth and family, regardless of where we physically meet. The Brien Center meets with youth and families without delay, offering easy and immediate access to care. Today, our waiting list extends no more than 10 days. The recent hiring of additional staff and our sensitivity to staff retention also extend our ability to offer accessible care and services.

Engagement Process

The Brien Center's intake system allows any youth or family member to make a referral, which eases entry into services. The Brien Center Intake Coordinator then makes a follow-up phone call to the family to discover and learn the youth and/or family's desires for treatment. Simultaneously, the Intake Coordinator explores referrals and provides the family with an initial appointment time before ending the initial contact. Other efforts to engage or follow-up with families who underutilize or prematurely drop out of services include:

- Ongoing efforts to identify and eliminate barriers that may cause premature termination or sub-optimal treatment outcomes from ICC services

- Place reminder phone calls to youth or families to promote attendance at appointments before the scheduled appointment time
- Train staff in engagement strategies
- Accommodate, to the extent possible, the family's requests for service delivery from The Brien Center clinicians and community support workers
- Collaborate with key stakeholders in the youth's care including State agencies, primary care providers, and other workers from relevant CBOs and/or providers

B. Relationships Within the Community

The Brien Center employs a youth-centered approach to developing and sustaining relationships with CBOs. These relationships promote the health and well-being of the youth we serve, based on holistic needs.

The Brien Center refers youth and families to community-based services and coordinates with social service agencies. We leverage our existing CBO relationships to ensure we meet that the needs of youth and families, as well as to further facilitate ongoing communication and information-sharing regarding the needs of youth and families. The Brien Center ensures that youth and families have timely access to needed community supports.

Our current and planned approaches include developing comprehensive referral and community resource guides for Engaged Enrollees and ACO staff; appointing liaisons to foster relationships and communication with community agencies; executing memoranda of understanding with providers and community organizations regarding the delivery and coordination of services; and, appointing dedicated points of contact for ACOs and MCOs as described in this RFR submission.

Section 6.4 Proposed Project(s) and Investment Plan

A. Project Description

Project 1

1. Name of Proposed Project

Enhanced Intensive Care Coordination and Pediatric Integration

2. Goal and Objectives

Goal: To improve care coordination, care planning, and care management for ICC-Engaged Members.

Objectives:

- Improve continuity and coordination of care
- Improve outcomes of care
- Enhance family-centeredness

3. Project Scope

For this project, The Brien Center will enter a collaborative arrangement with at least three pediatrician's offices in Berkshire County. The Brien Center's Intensive Care Coordinators (ICCs), in collaboration with the selected pediatric offices, will provide coordinated, on-site, interdisciplinary ICC meetings with pediatric representation to youth and families who are enrolled in MassHealth and qualify for ICC services. When possible, Wraparound meetings will include youth and families, State agencies, natural supports, and other key stakeholders to enhance coordination of care for these consumers significantly.

If awarded funding from this Request for Response, The Brien Center will acquire and implement the eHana electronic health record CSA module . This module will enable tracking of clinician and client information and activity as required for the CSA / ICC program, provide secure messaging to primary care providers and ACO partners, capture client signature authorizations and will link to our existing billing system, AR plus. In addition we will purchase communication devices to support facilitation of care coordination including, but not limited to: the purchase of laptops, tablets, smart phones, data service and wi-fi data card services for CSA staff to be able to access the eHana electronic Health Record (EHR) CSA module and the organization's I-Centrix EHR software remotely. Funds will also be expended for technical assistance in transitioning to the eHana software and integrating with the billing software. Using these devices, the ICC will be able to record the Discovery Process, Individual Action Plans, needs, progress and follow-up with ICC Enrollees and share such information with families, their Pediatrician, State agencies, Community-Based Organizations (CBOs) and other key stakeholders.

The Brien Center seeks to significantly enhance coordination of services across the full continuum of care through a combination of integrated care planning meetings and electronic sharing of Discovery Process and Individual Care Plan information. The opportunity to obtain

infrastructure funding to develop a better integrated approach with our local ACO will increase the level of integration and use of best practices for some of the highest-risk individuals among the ACO population.

In 2017, the EOHHS offered Fallon the opportunity to negotiate an ACO contract. The secure messaging component of the eHana software will be used to enhance communication and integration with primary care and other ACO providers. Pending support and confirmation from Fallon, CBOs and other providers who are seeking integrated care for youth and their families will be able to access consumer assessments, care plans, and ongoing needs information.

As part of workforce development, DISRIP funds will be used for three managers to take part in the University of Massachusetts primary care integration certificate program. This knowledge and material will be shared with ICC staff as ongoing staff training and development.

The Brien Center submitted a proposal to EOHHS to become the Behavioral Health Community Partner (BH-CP) for the Pittsfield and Adams service areas. If awarded the contract, The Brien Center will also work with families served by the ACO and contracted BH-CP. As a result, The Brien Center would be able to provide care to entire families, rather than splitting families between different ACOs or MCOs. Our ability to offer care to entire families will add another level of integration to care delivery.

If awarded Delivery System Reform Incentive Payment (DSRIP) funds, The Brien Center has identified the following pediatric practices to participate in this DSRIP initiative: MACONY Pediatrics, Northern Berkshire Pediatrics, Berkshire Pediatric Associates, and Berkshire Pediatrics of Community Health Programs (CHP).

In collaboration with these pediatric practices, The Brien Center will:

- Create a learning collaborative including pediatricians selected for participation, The Brien Center leadership and ICC staff and, a quality expert to oversee development and improvement activities.
- Bring together pediatricians, key office staff, ICC staff, State agencies, and other key stakeholders for a working meeting to discuss project development, challenges in managing youth with Serious Emotional Disturbance, successes that might be replicated, and opportunities to improve care delivery. We will hold collaborative meetings at least twice annually, in addition to ongoing contact with the ICC at the pediatrician's office.
- Invite Wraparound experts to discuss best practices with our Learning Collaborative members and to react to progress to date on our initiative.
- Support pediatric practices in integrated care delivery by providing services that include, but are not limited to:
  - Training pediatric practices on how to maximize fidelity to the Wraparound Model.
  - Increasing connectivity with, and referrals to, CBOs. The Brien Center ICCs will follow-up on referrals and ensure that youth and family needs are met, thereby easing the pediatrician's required level of effort.
  - Optimizing workflows and re-designing processes to maximize care integration.
  - Bringing key stakeholders to the pediatricians' office in a coordinated manner.

- Periodic, regularly scheduled meetings to participate in Berkshire Health System Pediatric Section meetings, where Brien Center management staff can update pediatricians across our service area on our Enhanced ICC and Pediatric Integration to seek further participation. Our goal will be to replicate our best practice approach in additional practices over time.
- Facilitate community-wide collaboration by inviting staff from pediatric practices to attend our Systems of Care Committee meetings.
- Identify and quantify metrics based on State requirements and quality improvement needs.

4. Proposed Deliverables

For this project, The Brien Center will provide EOHHS with the following deliverables:

- Joint ICC service delivery option at pediatricians' offices
- Sharing of Discovery documentation and Individual Action Plans among families, the youth's pediatrician and the ICC, State agency staff, and other key stakeholders as appropriate
- Improved outcomes, based on metrics that illustrate enhanced coordination and integration of care

5. Specific Use of DSRIP Funds and Support of Project Goals

If awarded Infrastructure and Capacity Building Funding, The Brien Center will use the award for:

Category	Detail
Prep Budget Workforce Development Investments	Training fees for three managers to take part in the University of Massachuetts primary care integration certificate program
Year 3 & 5 Workforce Development	Refresher training for University of Massachusetts primary care integration certificate program for 2 staff.
Prep period operational infrastructure investments	Allocated time of program managers, program supervisor and support staff. (see budget narrative) During prep period these positions will be involved in planning provider and family focus groups, improving communications with primary care and assisting staff through program transition. Development and printing of educational and promotional material for clients and primary care offices, planning of mini provider conferences, focus groups and incentives.
Year 1 Budget-Operational Infrastructure Investments	Allocated time of program managers, program supervisor and support staff. During budget period 1 these positions will be involved in implementation of ACO integration, provider and family focus groups, facilitating communications with primary care and assisting staff through program transition. Expenses related to mini provider education conferences on relevant subject matters. Three planned in Period 1, and four planned per subsequent budget period. Expenses related to client focus groups including incentives. Three planned in period 1 & 2, and two in periods 3–5.
Years 2-5 Budget-Operational Infrastructure	Expenses related to mini provider education conferences on relevant subject matters. Three planned in Period 1, and four planned per subsequent budget period. Expenses related to client focus groups including incentives for attendance.

Category	Detail
Investments	· Community education on CSA/ACO options and services.
Prep Budget-Technology Investments	· Acquisition and ehana implementation of CSA EHR module, licenses for MassHiway integration, CANS interoperability , integration with AR+ billing system; technical assistance related to data integration and transition with existing EHR and billing system; Purchase of laptops, smart phones, data service and Wi-Fi data card service for CSA staff to be able to access EHR and assessment material remotely. ·
Year 1 Budget-Technology Investments	· Ongoing cost of data service and Wi-Fi data card service for CSA staff to be able to access EHR and assessment material remotely. · · Ongoing ehana licensing fees and technical assistance on data analysis an integration of systems
Years 2-5 Budget-Technology Investments	· Replacement of laptops, smart phones; ongoing data service and Wi-Fi data card service for CSA staff to be able to access EHR and assessment material remotely. · •Ongoing ehana licensing fees and technical assistance on data analysis an integration of systems · . ·

NOTE: Laptops, smart phones, data services, and Wi-Fi data cards will be used for all MassHealth patients, not only those who are served by an integrated pediatric/ICC practice; the equipment will be assigned to the CSA /ICC program for use with all clients seen in the program. Software and tablets would be used to document the CANS, Discovery, and Care Planning processes, and to obtain provider and patient signatures

6. Internal Resources

The Brien Center will use a variety of internal resources to support the Enhanced ICC Pediatric Integration Initiative, leveraging The Brien Center's physical business location, and Information Technology (IT) systems and hardware.

Staff resources—which The Brien Center plans to use to develop, implement, and run this project—include the following:

- The Brien Center's Senior Management Team will participate on an in-kind basis. Specifically, the following individuals will serve as key internal resources on the project. A small portion of the direct program management will be allocated as a project cost in the prep period and period 1 (see budget and narrative) for planning and implementation :
  - James Mucia, LICSW, Division Director, Child and Adolescent Services (.05 % of total FTE)
  - Morgan Langlois, MA, Program Director, Community Service Agency (15% of total FTE)
  - Meg Ryan, M. ED., Program Supervisor/Senior ICC (15% of total FTE)
  - Carrie Crews, Program Coordinator/Senior Family Partner (15% of total FTE)

Resumes and job descriptions for individual staff members are included as **Attachment 6.4.A.1** and **Attachment 6.4.A.2** of this RFR submission.

7. Funds Allocations

Not applicable. See section 5 and budget narrative

8. Internal Evaluation, Measurement and Performance Management Strategy

The Brien Center will employ its existing Quality Management/Quality Improvement (QM/QI) process to evaluate, measure, and improve performance under the Enhanced ICC Pediatric Integration Initiative. In addition to The Brien Center's standard QM/QI process, we will employ specific metrics and strategies to identify opportunities to improve performance under this initiative.

The Brien Center will develop and implement a specific QM/QI and performance management strategy based on the types of data and domains EOHHS provided in the RFR and Model Contract as described above. We currently maintain a robust QM/QI department, which we will leverage for the CSA Infrastructure and Capacity Building Initiative. We will integrate care by establishing data-driven goals and processes within our organization and will share data with the Learning Collaborative, described in this RFR submission.

QM/QI staff who will be responsible for this initiative will report data findings, progress, and opportunities to improve to the Brien Center QM/QI Committee, which will suggest improvement opportunities to the Brien Center Board of Directors. Staff will further design interventions and track their effectiveness. The QM/QI Committee will report directly to the Board, which oversees improvement efforts for the overall organization.

For the CSA Infrastructure and Capacity Building Initiative, The Brien Center will outline specific program goals and an approach to achieve each. Our goals will be incorporated into The Brien Center's Development Plan and will serve as the basis for QM/QI efforts, which will also be embedded in the CSA's Quality Management Plan. Based on data findings, The Brien Center will outline specific QI initiatives, processes for performance monitoring, and our approach to continuously improve CSA Infrastructure and Capacity Building projects.

The Brien Center further understands that EOHHS will calculate the Contractor's Quality Score and DSRIP Accountability Score as described in Section 4.2 of Appendix A–CSA Quality and Accountability to the Model A Contract including claims-based measures, chart review measures, and member care experience surveys across the following seven domains:

- Prevention and Wellness
- Chronic Disease Management
- Behavioral Health/Substance Use Disorder
- Member Experience
- Integration
- Preventable Utilization
- Youth and Family Engagement

The Brien Center will employ data required by the State to drive all QM/QI efforts and plans to monitor and improve results required by the State continuously.

Specifically, we will monitor and measure data outcomes below. The data collected will directly measure Pediatric medical involvement in Care Planning and improved outcomes for youth and families.

Project 1: Enhanced ICC & Pediatric Integration

- Specific measures to evaluate impact:
  - We will internally track the percentage of youth transitioning from services with a successful "graduation" (i.e. a Wraparound term which refers to discharging of a youth and family after success achieving goals in their Care Plan).
  - We will internally track PCP involvement in the care planning process as reported on the care plan document
- Goals for the measure:
  - Improve percentage of youth graduating with goals met from 63% (current) to 75% by the end of Budget Period 3 (2020), increase by 4% each year and will evaluate quarterly.
  - Improve percentage of PCP involvement in care planning process from 18% (current/baseline) to 50% by the end of Budget Period 4 (2021), increase by 8% each year and will evaluate quarterly
- Evaluate quarterly for progress outlined above
- Internal data collection utilizing existing data tracking spreadsheets and care plan documentation and internal audits. Internal data is collected in a shared drive excel spread sheet with all ICCs reporting on each case.
- Jim Mucia, LICSW Division Director and Morgan Langlois, MA Program Director will track performance

Project 2

1. Name of Proposed Project

Increase ICC Workforce Capacity

2. Goal and Objectives

Goal: To improve the quality of care provided to ICC-Engaged youth and families through best practice training and development efforts.

Objectives:

- To enhance technical and clinical capacity within The Brien Center
- To maximize workforce development efforts by training senior ICC staff in best practices in Wraparound and leveraging their skills to train additional Brien Center staff
- To ultimately develop the capacity to conduct ICC training for staff and pediatricians using internal staff, trained in best practices in the Wraparound Model and System of Care Philosophy

3. Project Scope

For this project, The Brien Center will build capacity to train between three and five senior Brien Center staff in best practice approaches to Wraparound service delivery and Systems of Care Philosophy. These staff would be responsible for educating additional ICC staff. Ultimately, such training efforts will allow The Brien Center ICC Management Team and staff to make significant strides in maintaining and enhancing fidelity to the Wraparound Model and Systems of Care philosophy.

The Brien Center will identify and purchase intensive training services from the National Wraparound Implementation Academy or other appropriate organizations. In addition, The Brien Center will use services provided by the State's Wraparound Coaches to complement the intensive training services. Over time, our goal is to train a select group of The Brien Center staff in best practice approaches in Wraparound services, who can then train other The Brien Center staff.

Using this approach, The Brien Center will create an internal credentialing and re-credentialing process for ICC staff. In addition to the "train the trainer" model that will result from this initiative, we will utilize workbooks and curriculum previously developed by the State of Massachusetts as part of our certification and re-certification program. Bringing the training function into The Brien Center will allow our management team to stay current on best practices in ICC service delivery while providing the opportunity to train our own staff and increase fidelity to the Wraparound Model. This strategy, which enhances our ability to promote sustainability of training efforts, will be incorporated into The Brien Center's ongoing ICC training. The Brien Center believes that this approach will be replicable and can serve as a best practice model nationally.

Participation in developing training capabilities through external training for three to five staff will also allow The Brien Center to network with other CSA programs, creating the ability to share information on best practices and strategies to serve clients on an ongoing basis.

4. Proposed Deliverables

The Brien Center will provide EOHHS with the following deliverables because of this funding opportunity:

- Training curriculum for The Brien Center ICC Staff
- Training evaluations by staff to assess the staff's fidelity to the Wraparound Model
- A replicable model for other ICCs in Massachusetts where The Brien Center may serve as a best practice model nationally
- Certification and re-certification standards and requirements
- 100% of CSA staff trained in best practices related to the Wraparound Model and Systems of Care Philosophy

Planned Methods and Activities:

For this project, The Brien Center will:

- Review available holistic training programs regarding the Wraparound Model and a System of Care Philosophy including, but not limited to, training available from the National Wraparound Academy and the State of Massachusetts
- Develop criteria for selecting a training program
- Procure training services from the State and national resources to enhance The Brien Center staff expertise in treating ICC-Engaged Members in a manner that maximizes the opportunity to create a sustainable in-house training program
- Develop a training curriculum
- Develop standards and requirements for ICC certification and re-certification in Wraparound service delivery and System of Care Philosophy
- Implement training services for ICC staff
- Implement training for pediatricians and other clinicians who participate in the Integrated Care project
- Establish a sustainable approach to train additional The Brien Center Staff
- Evaluate value of training services based on The Brien Center staff feedback and improvements in EOHHS metrics associated with processes and outcomes of care
- Develop plans to replicate the curriculum and training model for other ICC programs
- Develop and execute additional training based on Workforce development needs and requirements

5. Specific Use of DSRIP Funds and Support of Project Goals

If awarded DSRIP funds, The Brien Center will use the award for the following uses:

Category	Detail
Prep Budget-Operational Infrastructure Investments	· Technical consulting on replacing current billable hour based productivity incentive to a new method that is relevant to the change in ICC payment structure
Prep period Budget Workforce Development Investments	Recruitment of difficult to fill ICC positions
Year 1 Budget Workforce Development Investments	· Attendance and related expenses to attend a national conference on Wrap around service delivery models for three supervisors. The intent is to bring this expertise in house utilizing train the trainer model. · · Recruitment of difficult to fill ICC positions
Years 3 and 5 Budget Workforce Development Investments	· Attendance and related expenses to attend a national conference on Wrap around service delivery models for two supervisors. The intent is to bring this expertise in house utilizing train the trainer model and provide refresher training. · · Recruitment of difficult to fill ICC positions

6. Internal Resources

The Brien Center will use a variety of internal resources to support the proposed initiative to Increase ICC Workforce Capacity, leveraging The Brien Center's physical business location, IT systems, and hardware.

Staff resources—which The Brien Center plans to use to develop, implement, and run this project—include the following:

- The Brien Center's Senior Management Team will participate on an in-kind basis. Specifically, the following individuals will serve as key internal resources on the project:
  - James Mucia, LICSW, Division Director, Child and Adolescent Services (.05 % of total FTE)
  - Morgan Langlois, MA, Program Director, Community Services Agency (15% of total FTE)
  - Meg Ryan, M. ED., Program Supervisor/Senior ICC (15% of total FTE)
  - Carrie Crews, Program Coordinator/Senior Family Partner (15% of total FTE)

Resumes and job descriptions are included as Attachment 6.4.A.1 and Attachment 6.4.A.2 of this RFR submission.

7. Funds Allocations

Not applicable.

8. Internal Evaluation, Measurement and Performance Management Strategy

For the CSA Infrastructure and Capacity Building Initiative, The Brien Center will outline specific program goals and an approach to achieve each. Our goals will be incorporated into The Brien Center's Development Plan and will serve as the basis for QM/QI efforts, which will also be embedded in the CSA's Quality Management Plan. Based on data findings, The Brien Center will outline specific QI initiatives, processes for performance monitoring, and our approach to continuously improve CSA Infrastructure and Capacity Building projects.

The Brien Center will employ its existing QM/QI process to evaluate, measure, and improve performance under the Enhanced ICC Pediatric Integration Initiative. In addition to The Brien Center's standard QM/QI process, we will employ specific metrics and strategies to identify opportunities to improve performance under this initiative.

We will integrate care by establishing data-driven goals and processes within our organization and will share data with the Learning Collaborative, as described in this RFR submission. The Brien Center currently maintains a robust QM/QI department, which we will leverage for the CSA Infrastructure and Capacity Building Initiative. We will develop and implement a QI/QM and performance management strategy based on the types of data and domains required by EOHHS in the RFR and Model Contract within our existing QM/QI structure.

The Quality Committee will report directly to the Brien Center Board of Directors, which oversees improvement efforts for the overall organization. ICC QM/QI staff will report data findings, progress, and opportunities to improve to The Brien Center's QM/QI Committee, which will suggest improvement opportunities to the Board. Staff will further design interventions and track their effectiveness with ongoing reporting to the Board as needed.

The Brien Center further understands that, if The Brien Center is selected as a CSA Contractor that receives Infrastructure dollars, EOHHS will calculate a Contractor's Quality Score and DSRIP Accountability Score as described in Section 4.2. of Appendix A–CSA Quality and Accountability

to the Model A Contract. This score will include claims-based measures, chart review measures, and member care experience surveys across the following seven domains:

- Prevention and Wellness
- Chronic Disease Management
- Behavioral Health/Substance Use Disorder
- Member Experience
- Integration
- Preventable Utilization
- Youth and Family Engagement

The Brien Center will employ data required by the State to drive all QM/QI efforts and plans to continuously monitor and improve results required by the State as described above.

Specific Measures for Increase ICC workforce capacity include:

- Specific Measures:
    - TOM scores measuring fidelity to wraparound. Results are reported to the CSA annually. Staff are observed two times between annually between July 1 and June 30.
    - Percentage of staff trained/completed internal credentialing process.
- Goals for the measure:
    - Maintain and/or improve overall TOM score. Current Key Element Score is 82%. The goal is to maintain or improve this relatively high score
    - 100% of ICC staff will complete internal credentialing process by the end of BP2 (2019), increase by 50% each year
- Evaluate quarterly for progress—assess above by measuring staff completing full enhanced Wraparound internal training.
- Data regarding TOM will come from MBHP. Training data will be tracked internally using excel spreadsheets
- Jim Mucia, LICSW Division Director and Morgan Langlois, MA Program Director will track performance

B. Project Team Description

1. Organizational Chart

The Brien Center's Senior Management Team and Child and Adolescent Team's organizational charts are included as **Attachment 6.4.B.1** and **Attachment 6.4.B.2.**

2. List of Current Staff Proposed for the Projects

A list of staff proposed for the projects appears below.

3. Proposed Staff to Be Hired

The Brien Center does not plan to hire new staff for the proposed projects.

4. Roles and Responsibilities of Team Members

The roles and responsibilities of all The Brien Center team members are described below in Table 6.4.1. of this RFR section.

The Brien Center proposes the following staff to participate in Project 1 and Project 2, which are described above. In addition, resumes and job descriptions are included as **Attachment 6.4.A.1** and **Attachment 6.4.A.2** of this RFR submission.

Table 6.4-1. Internal The Brien Center Staff

Name/Credential	Position	Project Role and Responsibilities	% FTE
Christine Macbeth, LICSW, ACSW	President and Chief Executive Officer	Accountable for contract and funding requirements	2%
Paul Hickling, MS	Vice President of Service Operations	Oversight of BH-CP contract if awarded	2%
Jeff Pringle, MBA	Vice President of Administration and Finance	Financial oversight of all budget and funding matters	2%
James Mucia, LICSW	Division Director Child and Adolescent Services	**Projects 1 and 2**: Provider Project Leadership for Project 1 and 2. Programmatic project oversight of ICC staff; project strategy and implementation oversight; quality oversight; and liaison to Senior Management on both initiatives	5%
Morgan Langlois, MA	Program Director, Community Service Agency	**Project 1:** Provide Day-to-Day Project oversight and ICC staff supervision Deliver ICC services in pediatrician's offices Develop and foster relationships with pediatric offices to integrate care **Project 2:** Participate in leadership training and develop core curriculum and certification program	15%
Meg Ryan, M.Ed.	Program Supervisor/Senior ICC	**Project 1:** Assist Program Director with project oversight and supervision Deliver ICC services in pediatrician's offices Develop and foster relationships with pediatric offices to integrate care **Project 2:** Participate in ICC training and maintain responsibility for training additional CSA staff	15%
Carrie Crews	Program Coordinator/Senior Family Partner	**Project 1:** Participate in the delivery of family-centered ICC services with family partners Develop and foster relationships with pediatric offices to	15%

Name/Credential	Position	Project Role and Responsibilities	% FTE
		integrate care **Project 2:** Participate in ICC training and maintain responsibility for training additional CSA staff	
Participating Pediatricians			
Community Health Programs: **Berkshire Pediatrics** **Northern Berkshire Pediatrics** **MACONY**	Participating Clinical Staff within Pediatrician's Office	**Projects 1 and 2:** Participate in integrated ICC meetings and coordinate care with ICC staff and other key stakeholders	2%

Participating Pediatricians include:

- CHP
  - Barbara Snyder, MD
  - Stephanie Taylor, PNP-C
- Berkshire Pediatric Associates
  - Dr. Jacqueline Jones MD
  - Dr. Betsy Valade DO
  - Dr. Diane Piraino MD
  - Dr. Gary Shalan MD
  - Dr. Alan Kulberg MD
- Northern Berkshire Pediatrics
  - Childs R. Art, MD
  - Jennifer S. Degrenier, DO
  - Beth L. Ellingwood, MD
  - Marc S. McDermott, MD
  - Kathryn B. Wiseman, MD
  - Dorothy Marie Madson, DO
  - Kris Savitsky, FNP
- MACONY
  - Deborah Buccino, MD
  - Ruby Chang, MD
  - Vitaly Nazarov, MD
  - Lisa Sylvia, MD

5. Project Management Approach

The Brien Center will create a project team to manage and oversee the work proposed within this RFR submission. The Team will include oversight from Senior Management (e.g., CEO, Vice President for Service Operations and the Vice President for Administration and Finance). In addition, the Team will include CSA staff and ICCs who will work more directly, on a day-to-day

basis to ensure that project designs and deliverables are met. James Mucia will be the overall Team Lead; Morgan Langlois and Carrie Crews will be responsible for working directly with pediatric offices and youth and families seen at those locations. Ms. Langlois and Ms. Crews roles will not be duplicated, given that they will be serving MassHealth Members in geographically distinct areas.

To manage this project, the Team will create a detailed project management plan that staff will be accountable for adhering to. The overall project management approach is reflected in the Implementation Plan, included as part of this RFR submission.

Mr. Mucia, Ms. Langlois, Ms. Crews and Ms. Ryan will work closely and collaboratively to manage the work associated with the project, meeting on a regular basis to review project deliverables, progress, and youth and family and pediatrician response to the initiative. The Team will maintain a level of attention to detail contained within the work plan; however, the Team will review fidelity to the Wraparound Model and stakeholder responses to the methodology at least weekly.

Mr. Mucia, Ms. Langlois, Ms. Crews and Ms. Ryan will also create a larger leadership team that will include pediatric representation, CBOs, State agencies, families, and other key stakeholders to discuss the initiative's overall progress. This leadership group will meet at least twice annually to review project progress and discuss opportunities to improve the initiative.

C. Implementation Plan and Timeline

Budget Periods: Preparation – Period 2

	Preparation Budget Period					Budget Period 1			Budget Period 2			
Task	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-June	Jul-Sept	Oct-Dec	Jan-Mar	Apr-June	Jul-Sept	Oct-Dec
Project 1: Enhanced ICC Pediatric Integration												
Identify pediatric practices for participation	DONE											
Develop design/ approach with pediatric offices and in provider focus group(s)												
Develop workflow re-design to incorporate Brien Center ICC staff and pediatric office staff												
Conduct pediatric staff training												
Conduct mini-conferences for pediatricians												
Implement integrated ICC meetings												
Assess integrated ICC meetings												
Continuously improve integrated ICC meetings												
Conduct regularly scheduled meetings with pediatricians												
Project 2: Increase ICC Workforce Capacity												
Identify optimal training on Fidelity to Wraparound processes												
Schedule staff participation to attend conferences and other training as appropriate												
Send staff to participate in training												

	Preparation Budget Period	Budget Period 1	Budget Period 2
Develop training curriculum, based on staff participation for additional CSA Brien Center staff			
Conduct ongoing training to enhance fidelity to the Wraparound model including staff and pediatricians			

Budget Periods: Period 3 – Period 5

	Budget Period 3					Budget Period 4			Budget Period 5			
Task	Jan-Mar	Apr-June	Jul-Sept	Oct-Dec	Jan-Mar	Apr-June	Jul-Sept	Oct-Dec	Jan-Mar	Apr-June	Jul-Sept	Oct-Dec
Project 1: Enhanced ICC Pediatric Integration												
Assess integrated ICC meetings												
Continuously improve integrated ICC meetings												
Conduct regularly scheduled meetings with pediatricians												
Project 2: Increase ICC Workforce Capacity												
Schedule staff participation to attend conferences and other training as appropriate												
Send staff to participate in training												
Develop training curriculum, based on staff participation for additional CSA Brien Center staff												

	Budget Period 3	Budget Period 4	Budget Period 5
Conduct ongoing training to enhance fidelity to the Wraparound model including staff and pediatricians			

D. Budget Report and Budget Narrative

The Brien Center has provided one Budget Report and one Budget Narrative, included in this submission as Attachment 6.4.D.1 and Attachment 6.4.D.2 of this proposal.

E. Sustainability

The Brien Center will sustainably fund the proposed infrastructure and capacity building investments during the Contract Term and following the initial Contract Term through:

For Project 1, Enhanced ICC and Pediatric Integration, The Brien Center will enhance sustainability by:

1. Building strong relationships with pediatric offices
2. Establishing new processes to serve ICC-Engaged Enrollees within the pediatric practices that participate as founding members of this initiative
3. Leveraging relationships with pediatricians who participate in this initiative from the outset to engage additional pediatric providers to join the project over time, thereby increasing the number of youth and families who receive integrated ICC services
4. Leveraging equipment purchased using CSA Infrastructure and Capacity Building funds over time in the original pediatric partner offices and in additional offices as pediatricians also wish to deliver integrated pediatric and ICC services.

For Project 2, Increase ICC Workforce Capacity, The Brien Center will enhance the sustainability of any work funded by the Infrastructure and Capacity Building funding by:

1. Maximizing training efforts funding by EOHHS and leveraging training efforts to maintain staff expertise.
2. Utilize our training and credentialing process to orient future ICC staff. Having an effective in-house training model will reduce the amount of time it takes to orient a new staff person to the Wraparound process which will ensure greater fidelity to the model.
3. Utilize current and future QI/QM processes to identify any areas of drift from the Wraparound process. This will allow management to address training needs and ensure the highest level of fidelity is being met.

Section 6.5 Coordination with ACOs, MCOs, and Primary Care Providers

A. Bidirectional Communication Between The Brien Center and Pediatric Practices

For the CSA program, the Brien Center plans on acquiring the CSA module of the eHana electronic health record software and utilizing this along with its current EHR, iCentrix for historical information. The eHana CSA module will be used to develop and execute discovery, safety and intensive care plans, track client progress and electronically secure releases and authorizations. The eHana software includes a secure messaging component which will allow sharing of information with Primary Care Providers (PCPs) and other providers, and for review of care plans and other Intensive Care Coordination (ICC)-Engaged Enrollee data.

B. Referral Management Protocols

The Brien Center will maintain a strict protocol for referral management, follow-up, and information sharing with pediatric practices. We invite all appropriate and family-approved stakeholders to Wraparound planning meetings. If medically involved and appropriate, Wraparound meetings will be held at medical offices. Wraparound outreach meetings at pediatrician offices will be tracked. A summary of our referral management protocol for follow up and information sharing is as follows:

- At the first meeting with the youth and family, The Brien Center obtains releases for all youth and family collaterals including pediatric, Behavioral Health (BH) and Community-Based Organization (CBO) providers.
- We record collateral contacts in a data file for each youth and family and agreed upon referral sources are added on an ongoing basis.
- ICC staff determines and initiate referrals, based on the youth and family's needs and preferences.
- ICC staff follows up to ensure that the youth and family received services as referred.
- If the youth and family did not receive services, the ICC staff works with the family to identify and address barriers; otherwise, results are tracked as follows:
  - Referrals are tracked from initial first contact, family assignment, first face-to-face meeting, and Wraparound planning. Waitlists are closely monitored by Brien Center staff. Referrals are further recorded and tracked based on the process described herein.
- The Brien Center staff record and share discussions or meetings about care delivery and integration among stakeholders in care management.
- An automatic two-way release of information is sent to medical practices with an immediate telephone or electronic follow up (email) to share information, as needed.

C. Team-based Treatment Planning in Collaboration with Pediatric Practices

Collaborative, team-based treatment planning with pediatric practices is a key component of The Brien Center's Project 1, referred to within this RFR submission as Integrated ICC and Pediatric Services. We intend to conduct team-based treatment planning in collaboration with pediatric practices on-site at a minimum of three pediatricians' offices. Such team-based treatment planning will occur at Discovery Team meetings with the youth and their family or caregiver as well as representatives from State agencies, CBOs, and other individuals involved in the ICC-Engaged youth's care delivery.

The Brien Center further seeks to expand this approach over time by engaging additional pediatricians who provide Primary Care to ICC-Enrolled individuals. In this manner, team-based treatment planning can expand to additional pediatric offices over the course of any contract that may arise from this RFR submission.

D. Timely Access to ICC Services

The Brien Center seeks to meet with youths and families quickly, offering the fastest access to care possible. Today, our waiting list is brief, extending no longer than two weeks for an initial ICC appointment. Recent new staff hires and our sensitivity to staff retention extends our ability to offer timely access to care. The Brien Center will measure access to ICC services on an ongoing basis and will hire additional staff if existing access becomes inadequate.

E. Connections to Social Services

We meet Enrollees' needs through a plethora of longstanding connections to a diverse set of organizations. A partial list of relationships appears below.

Community Organization	Description of Partnership
MassHealth MCEs	Clinical collaboration with providers through training, regular meetings w/ network managers from the Massachusetts Behavioral Health Partnership.
Ad Lib	Refer families for assistance with Supplemental Security Income/Social Security Disability Insurance, peer counseling, housing, Personal Care Assistance.
Advocacy for Access	Assistance with MassHealth.
Berkshire Children and Families	Provides Children's Behavioral Health Initiative Family Partners; parenting skills development and referrals to Family Resource Center (FRC); Subcontract with The Brien Center for Family Partner at the FRC.
Department of Developmental Services (DDS)	Referrals and collaboration for youth meeting criteria for developmental diagnoses. Engagement of DDS case managers and other affiliated Care Planning Team (CPT) meetings
Department of Mental Health (DMH)	Referrals made for youth with serious emotional disturbance for respite, therapeutic day treatment, and outreach services. Engagement of DMH staff and other affiliated supports in CPT meetings.
Department of Children and Families (DCF)	Collaboration with social workers and families in meeting service plan goals; and referrals for outreach and day treatment services. Engagement in CPT meetings.
North Berkshire	Sharing information to provide services to the community; referrals to The Family

Community Organization	Description of Partnership
Community Coalition	Place; subcontract with The Brien Center for Family Partner at The Family Place.
Railroad Street Youth	Provide groups to youth at the program and education.
Schools	CSA staff support families in successfully collaborating with schools to best meet the needs of the ICC-Engaged youth through frequent communication and attendance at school team meetings. Schools include Pittsfield; North Adams; Central Berkshire; Northern Berkshire School Union; Southern Berkshire: Adams-Cheshire; BART Charter and Technology School.
MACONY Pediatrics	Collaboration and engagement of Nurse Care Coordinator and/or PCP in CPT meeting and planning process for youth to address both behavioral and physical health needs. CPT meetings take place in PCP office.
Berkshire Housing	Housing needs for unification with family and children.
Elizabeth Freeman Center	Domestic Violence services.
BUW/NBUW	The Brien Center actively participate in BUW-related programs.
NAMI	Collaboration for training and community events.
Multicultural Bridge	Translation services and training on cultural competency.
Berkshire Health Systems	Collaboration on acute care, psychiatry, and primary care.
Child Care of the Berkshires	Collaborate at Systems of Care meetings; refer for additional family supports and daycare; parenting skills development.

The Brien Center will leverage and build on existing relationships and collaborations to enhance access, integration, and continuity for Enrollees. One of our organizational goals is to grow our collaborative efforts with CBOs over the course of the BH-CP Contract.

To meet this goal, we will implement initiatives that address social determinants of health by enhancing our ability to address housing, food, safety, and other issues, breaking down existing silos and integrating services. For example, we participated in BHS' Community Health Needs Assessment to inform efforts to better meet the needs of the communities we serve. We will continue working side-by-side with community organizations and stakeholders to find ways to help youth and families achieve their recovery goals.

As a CSA, The Brien Center organizes System of Care Committees (SOCC) countywide. Due to Berkshire County's size and diversity, we operate three SOCCs in each part of the county North, Central, and South. Through the SOCCs, The Brien Center builds on and enhances existing relationships among participants, which include local social services agencies like the DCF, DMH, Department of Youth Services, Bureau of Substance Abuse Services, and Probation.

To inform and update staff, The Brien Center will develop a community resource guide; staff training on community resources as part of our overall approach to training as presented in Project 2, and we will hold interdisciplinary care team meetings where we inform the broader team about CBO services. We will maintain and update current information on all community resources and regularly.

CSA Budget Report

Community Counseling of Bristol County, Inc. (CCBC)

Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites	1	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate	NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)	108	108	108	108	108	108	
Estimated Funds	$ 94,992.00	$ 75,600	$ 45,360	$ 32,400	$ 28,512	$ 12,960	**$ 289,824**
At- Risk Withhold Rate			5%	10%	15%	20%	
Withhold			$ 2,268	$ 3,240	$ 4,277	$ 2,592	**$ 12,377**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 94,992.00	$ 75,600	$ 43,092	$ 29,160	$ 24,235	$ 10,368	**$ 277,447.20**

Investment Projects	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Project 1 Name: Workforce Development Project							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ 9,789	$ 3,000	$ 3,000	$ 2,000	$ 1,000	$ 1,000	$ 19,789
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ 3,000	$ 1,000	$ 1,000	$ 500	$ 500	$ 500	$ 6,500
Project 1 Total	$ 12,789	$ 4,000	$ 4,000	$ 2,500	$ 1,500	$ 1,500	$ 26,289
Project 2 Name: *Operational Infrastructure*							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -		$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ 400	$ 1,800	$ 2,400	$ 2,400	$ 2,400	$ 2,400	$ 11,800
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ 5,167	$ 23,250	$ 31,000	$ 31,000	$ 31,000	$ 31,000	$ 152,417
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 2 Total	$ 5,567	$ 25,050	$ 33,400	$ 33,400	$ 33,400	$ 33,400	$ 164,217
Project 3 Name: *Technology*							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 3:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ 53,000	$ 11,000	$ 3,000	$ 1,000	$ 1,000	$ 1,000	$ 70,000
Technology for Service Delivery	$ 10,000	$ 2,000	$ -	$ -	$ -	$ -	$ 12,000
Other Technology Expenses	$ 5,000	$ 2,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000	$ 11,000
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 3 Total		$ 68,000	$ 15,000	$ 4,000	$ 2,000	$ 2,000	$ 2,000	**$ 93,000**
Total Project Costs		$ 86,356	$ 44,050	$ 41,400	$ 37,900	$ 36,900	$ 36,900	**$ 283,506**
Indirect Costs/ Administrative Overhead Rate	10%	$ 8,636	$ 4,405	$ 4,140	$ 3,790	$ 3,690	$ 3,690	**$ 28,351**
Investment Projects Total		$ 94,992	$ 48,455	$ 45,540	$ 41,690	$ 40,590	$ 40,590	**$ 311,857**

CSA Budget Report - Budget Narrative Prep Budget Period

CSA_Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name: Workforce Development
DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-Eng*
2 *(2) Strengthening fidelity to Wraparound processes, including the care planning,*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Operational Infrastructure
DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E*
2 *(2) Strengthening fidelity to Wraparound processes, including the care planning*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Secure Video Conferencing	$ 400.00
Total Other Technology Expenses	$ 400.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Begin training staff and addional team members on how to utilize the secure video conferencing. The cost of secure video conferencing is $200 per month.
Updated Narrative 12/12/17
This is the monthly cost for the video conferencing; we want to start using it in the PBP so that staff can get comfortable with the technology. All CSA staff will be trained, a total of 22 staff members. The vendor will provide initial training to CSA managers, who will then train the rest of the staff and eventually community providers, including pediatricians, who are willing to have it installed in their offices.

Project 3 Name: Technology Project
DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E*
2 *(2) Strengthening fidelity to Wraparound processes, including the care planning*
3 *(3) Improving timely access to ICC services for children eligible to receive ICC an*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Electronic Health Record	$ 20,000.00
Care Management Programming	$ 10,000.00
WRAP Documentation Development	$ 5,000.00
CANS Interoperability Project	$ 3,000.00
CSA Quality / Accountability Measure Repor	$ 5,000.00
Professional Services	$ 10,000.00
Total Development and Adaptation of EHR and Care Management System	$ 53,000.00

*Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined: Electronic Health Record (EHR) will be used for all clients in the CSA. The EHR has been developed by eHana and is currently in use with other CBHI entities. The projected cost of the electronic record is $20,000. The Care Management Programming will be complete to add the Data Sets rerquired to the existing eHana EHR. This programing will allow for tracking each client during the case management process. These programming changes will only apply to the CSA. The projected cost of these programming changes is $10,000. WRAP Documentation is a strengths based documentation module that will work with Care Management and EHR packet.**
*CANS Interoperability Project will enable a more efficient data collection and reporting system.*CSA Quality / Accountability Measure Reporting to implement data tracking, dash boarding and reporting necessary to support Quality Measure capture, management and submission**
*Professional Services including Project Management, Business Analysis, Training, Development and Support for eHana to develop and program the systems described above, working in concert with CCBC to allow for specific needs regarding analysis, training and support. (*shared with other CSAs utilizing eHana)*

Technology for Service Delivery

Description of Expense	Cost
IPad	$ 5,000.00
Tablets	$ 3,500.00
Smart Phones	$ 1,500.00
Total Technology for Service Delivery	$ 10,000.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Purchase IPads, Tables and Smart Phones for use in the program to use with clients.
*IPads 5 * $1,000 each = $5,000*
*Tablets 7 * $500 each = $3,500*
Smart Phones 10 $150 each = $1,500*
Updated Narrative 12/12/17
CCBC will be using both iPads and tablets, we plan to utilize both types of technology to fit the technology to staff members skills and to determine which type of technology is most useful to the CSA program. A total of 12 CSA staff members will have this mobile technology. The staff will use the devices to collect and record data remotely when they are meeting with children, families and other stakeholders. They will also be able to use the tablets to submit data into the client's eHana record and check on any new notifications that come into eHana relating to client emergency department or inpatient admissions.

Other Technology Expenses

Description of Expense	Cost
Mass HIway	$ 5,000.00
Total Other Technology Expenses	$ 5,000.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Funds for the installation and implementation and connection of the Care Management System to the Mass HIway. This is a quote from our service vendor, it is expected to be a one time expense.
Updated Narrative 12/12/17
The cost is a onetime charge from CCBC's EHR vendor in order to do structural modifications and programing to allow for the use of the Mass HIway. The vendor did not quote the modifications in a cost per hour structure.

Project 4 Name:
DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:
DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:
DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:
DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Workforce Development - Prep Budget Period

Project 1 Name: Workforce Development

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Indeed Recruiting	$ 4,789.00
Robert Half Placement Fee	$ 5,000.00
Total Recruitment Expenses	$ 9,789.00

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:
Utilizing Indeed Recruiting to search for qualified staff, will utilized sponsored advertising. The cost for CSA sponsored advertising will be $4,787.
CCBC will utilize Robert Half Placement Firm to place a qualified candidate for the Data Analyst / Quality Management staff member. The budgeted expense for this fee $5,000. Since the position is a .5 position only half of the placement fee will allocated to CSA.
Updated Narrative 12/12/17
The way the Indeed Fee works is that we pick a job to be "sponsored". By "sponsoring" the job Indeed continues to pull the job that is sponsored up higher on the feed of jobs. Usually, once a job is pulled onto the Indeed site it falls further and further down the list as new jobs are placed on the Indeed jobs list. By sponsoring a job Indeed continues to place the sponsored job at the top of the list. The fee is assessed by the number of "clicks" or "looks" the job gets, each click costs a portion of the total agreed fee. The fee is like a budget, once the budget is spent the job in no longer sponsored. It is difficult to say how long the fee will keep the job up on the top of the list. From prior experience our sponsored jobs run for about 4 to 6 weeks.
The Robert Half placement fee is for the Full-time Data position, half of which is dedicated to CSA and half to BH CP. The projection for the total fee for the Data position will be at least $10,000 based on 20% of the annual salary, of which $5,000 would be allocated to the CSA DSRIP. When finalizing our budget for the Prep Period we only had $1800 remaining to allocate to the cost of the placement fee. However, since we will be moving some funds due to number 3 below, we will move up to $5,000.

Training Expenses

Description of Expense	Cost
Staff Training	$ -
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Updated Narrative 12/12/17
Removing training line from budget.

Staff will spend 4% of their time in the months of May and June learning the new Care Management System and the Electronic Health Record. The Calculation was made by taking 4% of total monthly salaries, 4%$102,087 * 2 months = $8,167*

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Operational Infrastructure

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name: Technology Project

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 1 Name: Workforce Development

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Training and Collaboration Events	$ 3,000.00
Total Other Operational Expenses	$ 3,000.00

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

*Three meetings with PCP offices to connect with the PCP and their core team. It is expected that 10 office staff and 5 CCBC staff will attend each event. Cost includes the cost of Breakfast or Lunch for the attendees at $15 per person for a total of $675 = 3*15*$15.*

Provide a motiaational training for PCP offic staff, inviting approximately 20 offices
*Marketing for Meeting $5 per invitation * 20 Offices = $100*
Rental of Space = $125
*Motativation Interviewing Books for Offices and PCPs $40 * 40 = $1,600*
Materials for Meeting $5 per attendee = $100
Coffee and Snacks for Meeting $10 per attendee = $400

Project 2 Name: Operational Infrastructure

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Data Analyst / Quality Management	$ 50,000.00	0.5	2	$ 4,166.67
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0.5		$ 4,166.67
	Fringe rate	24.0%	Total Fringe	$ 1,000.00
Total Program Staffing including Fringe				$ 5,166.67

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Salary for the Data Analyst / Quality Manager for two month. This position will support the CSA in meeting targets in Quality Slate and achieving goals in CSA Development Plan.
Updated Narrative 12/12/17
Develops measures for quality metrics in CSA DSRIP RFR; ensures staff competency in tracking key measures of access and quality; works with the eHana software to develop reports on the quality metrics; and develops reports to PCCs and ACOs on client activities The Data Analyst also ensures quality of data exchange between CCBC's CSA and outside resources such as Pediatricians, Emergency Departments and ACO Care Management Programs.

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name: Technology Project

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate: 10%

Provide a brief description of how the Indirect Cost/Administrative Overhead rate was determined: The overhead rate was calculated by utilizing the CCBC overhead percentage of 10% for last fiscal year (FY 2017) . Updated Narrative 12/12/17

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS March 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
	Technology	Implement Care Management Software	03/01/18	12/31/22	**Technology**	IT Staffing including Fringe	Hire IT staff skilled in EMR and Care Management software	Employee on board at CCBC			Care Management software in place	Staff using software and EMR for all CSA clients and getting support from data analyst		
	Technology	Implement Care Management Software	12/01/17	12/31/18	**Technology**	Development Adaptation of EHR and/or Care Management System	Beginning of installation of EMR and Care Management Platform	Initial version of CSA software reviewed by CCBC CSA Staff			Care Management software in place	Staff using software, entering data to enable reporting features;		
	Technology	Implement Care Management Software	03/01/18	12/31/22	**Technology**	Technology for Service Delivery	Reporting formats established for CSA program	Draft reports available from software			Report specifications identified	Data analyst meets with eHana on report content		
	Technology	Implement Care Management Software	03/01/18	12/31/22	**Technology**	Other Technology Expenses	Support for CSA Staff established	CSA Staff have identified help desk within CCBC			Training with CSA staff and data analyst	Agenda for staffing training on eHana modules		
	Staff Recruitment	Identify qualified candidates for Data Analyst/Quality Manager	01/01/18	04/30/18	**Workforce Development**	Workforce Development staffing including Fringe	Interviews with qualified candidates	COO has interviewed 2 candidates			Data Analyst functioning as part of CSA	Data analyst sharing outlines of potential reports with CSA staff at staff meetings		
	Staff Recruitment	Identify qualified candidates for Data Analyst/Quality Manager	01/01/18	04/30/18	**Workforce Development**	Recruitment Expenses	Interviews with qualified candidates	COO has interviewed 2 candidates			Data Analyst functioning as part of CSA	Data Analyst on agenda for staff meetings		
	Staff Training	Improve skills of CSA Staff in working with children with co-occurring medical issues	04/01/18	12/31/18	**Workforce Development**	Training Expenses	Final Plans for Training	Established agenda, dates and locations for Training			Initial trainings held	Agenda for training in May, 2018		
	Staff Recruitment	Identify qualified candidates for Data Analyst/Quality Manager	01/01/18	04/30/18	**Workforce Development**	Retention Expenses	Hiring of qualified candidate	Candidate on staff at CCBC			Data Analyst on board and integrated into CSA Program	Data Analyst on agenda for staff meetings		
	Staff Recruitment	Workforce Development	04/01/18	12/31/22	**Operational Infrastructure**	Operation Staffing including Fringe	Onboarding of Data Analyst/Quality Manager	Identified candidate has a firm start date. and hire			Data Analyst on board and integrated into CSA Program	Data Analyst on agenda for staff meetings		
	Technology	Establish remote video communication with PCCs	04/01/18	12/31/22	**Operational Infrastructure**	Other Operational Expenses	Complete review of Zoom video conferencing	Staff report to CEO on feasibility of Zoom software			Zoom video conferencing installed in 3 pediatric offices and testing completed	Meeting between CSA and Pediatric office to test Zoom Video Conferencing software		
					Operational Infrastructure									
					Operational Infrastructure									

6.2 Executive Summary

6.2 A. Community Counseling of Bristol County (CCBC) is pleased to submit this proposal to MassHealth to strengthen our Community Service Agency (CSA) program and enhance our role in MassHealth's innovative DSRIP and ACO initiatives. We believe that we are well positioned to engage children with Severe Emotional Disturbance (SED) and their families in a strength-based, family-centered approach to behavioral health problems and primary care conditions such as diabetes, asthma, and obesity that frequently co-occur with our population in the Attleboro-Taunton area.

CCBC has consistently been one of the state's highest performing CSA's on the Wraparound Fidelity Index (WFI). Still we seek to improve in a number of areas as identified in our Development Plan. These improvement goals include:

1) Increase staff knowledge of different cultures in the Attleboro-Taunton area; translate the knowledge of that culture to the Wraparound process to enrich and inform the Care Planning Teams process; and

2) Increase skill sets of CSA staff to help families transition out of the CSA to community-based natural supports and ongoing outpatient behavioral health services.

We are fully confident that careful management of the DSRIP resources over five years for our CSA will support CCBC as an active partner with area ACOs in improving health outcomes, expanding the culture of a strength-based and family-centered approach with area pediatricians, specialty providers and hospitals. At the same time, CCBC will also maintain timely access; report on quality metrics and enhanced and efficient information sharing through our electronic health record (EHR) eHana via the Mass HIway. The EHR is currently being updated to contain the necessary fields and data sets to handle the care management reporting requirements.

6.2 B. CCBC's strengths as a CSA include:

- Timely access to Intensive Care Coordination (ICC) services; there are no families on our waiting list;
- A high rate of engagement and retention of families in the Wraparound process as measured by improved scores on Strength-based approach to families;
- Expanded networking into the community by the CSA Program Director; and
- Networking with local police departments.

In addition to the need areas described in Section A. above, CCBC's CSA is working on improving the Team Observation Measure score (TOM) related to Individualizing Care and Persistence. Another need is to increase the capacity to share information on the aggregate CSA population and the associated Total Costs of Care from a population health perspective.

6.2 C. CCBC maintains an agency-wide commitment to timely access to services. We are one of the few outpatient mental health clinics that has an "Open Access" policy where any client – child or adult – can come to the agency and receive a clinical evaluation ***the same day.*** <u>This policy applies to the ICC services where we have no families on our waiting list.</u>

6.2 D. CCBC is very excited about our plan to improve care coordination, care planning and care management for ICC-engaged children with SED and their families. In our proposal, we list three projects that will strengthen our ability in these areas and align the agency's ICC activities more closely with the activities of the ACO-affiliated pediatricians. These projects include:

1. Installation and Implementation of the eHana EHR and Mass HIway connection to improve data sharing functionality with PCCs, ACOs, MCOs and MassHealth, and reporting on quality measures per Appendix A's Quality Slate;
2. Training of CSA staff on improving skills overall, addressing the needs of children and families from diverse cultures, and engaging PCCs in the Care Planning Process; and
3. Strengthening CCBC's technology infrastructure to share information via the Mass HIway and through installation of a HIPAA compliant secure video conferencing capacity to encourage remote participation by PCCs in the Care Planning process.

CCBC is well-positioned to implement this plan. In addition to providing timely access to care and scoring high on the WFI and TOM measures, CCBC has established strong working relationships with over 20 pediatric offices in the Attleboro-Taunton area. Our relationships extend beyond sharing information on treatment plans and results of physicals. ICC's have conducted care planning meetings at the offices of pediatricians when requested by the family. We have also expanded care planning teams to include specialty medical providers and Emergency Room staff for children and families with complex co-occurring medical and behavioral health conditions. ***All of these efforts have been built on a foundation of collaboration with Steward Health Care through four Infrastructure Capacity Building (ICB) contracts that includes data sharing and collaborative treatment planning. There is a joint commitment to continue as Steward transitions from a pilot ACO to a fully operating ACO on January 1, 2018, including real-time notification of ED or inpatient admissions of shared clients.***

6.2 E. CCBC continues to work on the two Goals established in our CSA Development Plan:

1. Increase staff knowledge regarding various cultures and how culture impacts the many aspects of a family's life; translate the knowledge of that culture to the Wraparound process to enrich and inform the Care Planning Teams process; and
2. Increase skill sets within the phase of transition for families and youth engaged in ICC Services.

The activities related to Goals 1 and 2 are ongoing within the CSA and across CCBC as a whole. Interventions include facilitated open discussion among CSA staff to solicit individual definitions of culture and translate that definition to the clients we serve. CSA staff focuses on improving their skills and competency to align individual care coordination to the background in which the individualized Care Plan is developed. Staff continues to improve their skills at helping families articulate the influence of their culture as a resource or an obstacle to achieving the goals of the Care Plan. Staff then revisits the cultural context in subsequent care planning meetings.

Another activity of Goal #1 will be to supplement the internal discussions with regional trainings on engaging families from diverse cultures into the Wraparound planning process. The region has diverse populations, including Cape Verdeans, Portuguese, and Asians. Each culture has its own unique context in which behavioral health needs are identified, accepted and addressed. Finally, supervisors will review staff assessments to make sure that the cultural component is addressed, and indicates that the staff explored the family's cultural orientation in initial meetings.

Goal #2 represents a more focused challenge in improving the Wraparound process. One element is for increased supervisory oversight of the transitions out of ICC to outpatient counseling and natural community supports, transitions from higher levels of care back to community-based services, and transition to adult services for clients who are turning 21. The ICC supervisors will enhance the process by reviewing documentation on care planning to ensure a strength-based approach at the time of transition. Supervisors will be trained to track staff documentation and follow up to make sure any gaps are addressed by staff, especially around transition.

6.2 F. The installation of capacity for a HIPAA compliant secure video conferencing process will be a major step in improving coordination with pediatric primary care providers. The ability to share clinical information via the Mass HIway is a second method to achieve better coordination and improve health outcomes. CCBC's operation of the Psychiatric Emergency Services Program (ESP) is another point of contact that will allow for timely access to care for the child and family *outside of the Emergency Room and more restrictive settings* with timely input from the pediatrician, specialty providers, outpatient behavioral health providers and the ICC staff. CCBC has already been developing the relationships with over 20 pediatric offices in the Attleboro-Taunton area and is poised to enhance the communication through video teleconferencing and the Mass HIway.

Section 6.3 Communities Served and Community Engagement

6.3 A. The Community Services Agency (CSA) operated by CCBC covers the Attleboro-Taunton area as designated by the Massachusetts Executive Office of Health and Human Services (EOHHS) MassHealth. The communities around Taunton and Attleboro are largely suburban and poor rural communities. They include Berkley, Dighton, Mansfield, Norton, North Attleboro, Raynham, Rehoboth and Seekonk.

The CCBC CSA meets the needs of children with SED and their families by practicing the principles of Wraparound Model of care with consistently high scores on the Wraparound Fidelity Index (WFI) indicating successful outreach and engagement with the wide range of families in these communities. The CSA convenes monthly Systems of Care (SOC) meetings to which all community stakeholders are invited. This forum provides an open setting in which solutions to pressing problems of youth with SED can be developed by strengthening relationships among participants. We will build on the prior successes of the SOC meetings that include increasing access to natural community supports and resources such as the YMCA, Boys and Girls Club, and Girls Inc. The SOC meetings have also supported connections of local PCP's and pediatricians to the Massachusetts Child Psychiatry Access Program (MCPAP).

The Wraparound approach includes the child's primary care, overall wellness, prevention of chronic health conditions, and overall community health and support for the child and family. CCBC's CSA will promote the health and well-being of children and families through increased fidelity to the Wraparound process with increased emphasis on a strength-based approach to families; identification of natural community supports and social service supports, a family-centered approach to care planning; and timely, respectful, and responsive sharing of information with all involved stakeholders.

The CSA's customized EHR will enhance communication with the PCCs working with the child to allow for more timely review of critical information. This will result in more informed intervention by all of the stakeholders, especially for children with chronic medical conditions - such as diabetes or asthma - and co-occurring severe emotional disturbances - such as attention deficit disorder or post-traumatic stress disorder. The EHR will also allow sharing of information with the ACOs so that specialty services, emergency services and inpatient services can be accessed when needed and transitions of care can be facilitated smoothly. Finally, the CSA's module will incorporate natural community supports, or their absence, into the family assessment and identify community gaps that a broader range of stakeholders can address.

6.3 B. CCBC has a long history of collaboration with local police departments, court clinics, and Department of Child and Families (DCF) youth. CCBC has shared crisis safety plans with the police to prevent escalation of crisis situations when law enforcement is involved. The police are invited to the CCBC Systems of Care (SOC) meetings in the Attleboro-Taunton area. The CCBC CSA SOC has regular collaboration and attendance from the court clinics, Department of Youth Services (DYS), Department of Mental Health (DMH), DCF and Juvenile Justice partners.

As stated above, CCBC serves on DCF's Advisory Committee for the Attleboro-Taunton catchment area and invites DCF personnel to attend the monthly CSA SOC meeting. The CSA

staff also participates in an interagency collaboration meeting for our area which includes DCF, DMH, DDS and DYS to facilitate coordination of care for families and youth we serve.

Our CSA has established working relationships with residential programs operated by DCF, DYS, the Bureau of Substance Abuse Services (BSAS), and DMH in the Attleboro-Taunton catchment area. The CSA Program Director has a working relationship with the DCF Area Office for the Attleboro-Taunton area.

CSA staff attends Individual Education Plan meetings with most of the schools in the area. Many school districts, including Attleboro, Taunton, North Attleboro, Norton and the Bi-County Collaborative have requested CCBC to conduct trainings and education with their staff to increase knowledge of CSA and CBHI services. Staff have attended various professional development days and provided education to various school staff. In addition, schools have been consistently welcoming to our CSA hosting Care Plan Meetings within the school setting in order to foster collaboration between home-based and school based providers. The work of the CSA staff complements the work of CCBC outpatient staff that provides counseling and consultation in over 50 schools in the Southeast area, working with teachers, guidance counselors and families to address behavioral health needs of students in the schools.

The CSA has developed strong working relationships with pediatric practices in the area. We are actively involved in the coordination and integration of primary care and behavioral health care, especially for children with complex medical conditions, even convening meetings in the offices of the pediatrician in order to facilitate his/her participation with the family.

The CSA routinely collaborates with PCP and pediatric providers. We reach out to every PCP for each client we serve to inform them that we are working with their patient, and we provide the releases obtained and send a two-way communication form to support collaboration. Staff regularly provide to PCP's each updated care plan developed for the client. ICC's have routinely partnered with PCP's and parents to support PCP's connecting to the MCPAP program to foster them providing medication assistance to the child while we navigate the barrier of lack of child psychiatry throughout the state. CSA staff also connects directly with PCP offices to review any child that has medical and mental health needs to specifically understand how the medical needs may be contributing to any social, emotional and/or behavioral needs seen across the life domains. The CSA utilizes our consulting child psychiatrist to support connection to PCP's when working with a child that has complex medical needs and has a direct correlation to their emotional and/or behavioral needs. The CSA participates in the Southeast Cluster meeting, which is facilitated by MBHP. This meeting is a forum and collaboration used to strengthen relationships between mental health providers and PCP's.

The CSA DSRIP Plan will include strategies to strengthen the communication with pediatricians, schools, DCF, behavioral health providers and social service providers via enhanced capacity to share information electronically and address gaps in care more responsively.

6.3 C. CCBC will incorporate our current partnerships as described in Section 6.3.B along with planned collaborations to develop proposed projects that will be described in Section 6.4.A. in the areas of Workforce Development, Operational Infrastructure, and Technology.

CCBC's DSRIP Participation Plan will include expanded training on pediatric medical conditions for the CSA workers and convene collaborative learning forums with pediatricians from the ACO's serving Taunton and Attleboro, including Steward Health Care and BMC ACO.

The CSA continues to make improvements in the program based on the goals established in the Development Plan. The community collaborations will provide a foundation to develop a broader public health focus for better integrated interventions and improved understanding of community health. These goals will be reached with better sharing of clinical information and the aggregation of encounter data to demonstrate how chronic conditions such as asthma and diabetes can be treated on a community health basis. CCBC will work with the ACO's to identify pediatric "hot spots" with high concentrations of pediatric health conditions and bring the data to the forums in which CCBC participates to generate broad based solutions. This approach is one method of addressing social determinants of health, a key component of the ACO initiative. This approach for children's populations has been validated in a recent article from Health Affairs. It should be noted that the assessment of the family's community described in the article relating to "geo-factors" closely parallels the Strengths, Needs and Culture Assessment conducted by the Intensive Care Coordinator (ICC) at the outset of the Wraparound process.

The DSRIP will allow the ICC's to strengthen facilitated care plan meetings and crisis/safety planning meetings in Sturdy and Morton ER's with the participation of the attending nurses and doctors. The project will also allow for more creative work to develop plans for youth who are boarding in the ER to assess if the youth can return to the community safely with a collaboratively designed follow up plan.

The DSRIP Participation plan will strengthen CCBC's capacity for care planning when CSA youth require medical hospitalization and/or surgery to address complex medical needs. CCBC will partner with these doctors, hospitals, and specialists and participating ACOs to develop care coordination plans and ensure that medical concerns are being addressed appropriately. These interventions will lead to integrated care plan development, addressing both medical and behavioral health needs.

SECTION 6.4 – DSRIP PARTICIPATION PLAN
6.4 A. Project Description:
6.4 A.1 WORKFORCE DEVELOPMENT

6.4 A.2 The Workforce Development Project will support the RFR Goals of "Fostering strong integration with ACOs and primary care providers" and "Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families." At the same time the Workforce Development Project will support the CSA's Goals in our development plan. Goal #1 is to increase staff`s knowledge of the culture of families served and Goal #2 is to increase skill sets of CSA staff to help families transition out of the CSA to community-based natural supports and ongoing outpatient behavioral health services. Additionally, the Workforce Development Project's goal is to improve the quality of care delivered to children with SED and their families. The project will have two components, including 1) establishment of enhanced workforce development trainings within CCBC for CSA staff; 2) collaboration with other CSA providers in the Southeast to conduct a regional events for partnership with pediatricians and ACO's.

The project will develop training topics to address gaps identified in the CCBC Development Plan, notably improving use of natural community supports with families. Additionally, trainings will also address the evolving relationship with ACOs and MCOs highlighted by the development of joint trainings with PCCs and their ACO representatives. For families that present with complex needs, trainings will be developed to focus on the following: how to coordinate all of the providers, address needs in a timely manner, access specialists and other supports when needed to maintain the child in his/her family, and establishing a language around care planning with PCCs that includes increased focus on a family-centered, strength-based culturally sensitive approach to children and their families. The training will improve the capacity of the CCBC CSA to share service utilization data with the members of the care team to document gaps in care at the outset and paths to service delivery that address those gaps as a result of the intervention

The CSA will commit to ACO /PCP/CSA collaboration events and/or other staff training opportunities. Preliminary conversations have occurred to foster regional collaboration with other CSA's on these endeavors and will continue once RFR funding is officially awarded. We will explore possible regional collaboration with other CSA's within these projects however if collaboration cannot occur we will foster these collaboration and training projects independently. Specifically ACO/PCP/CSA collaboration would foster an event or events to allow local ACO's, PCP's/ pediatricians and CSA's to gather to offer education and training on CBHI and CSA services, develop relationships and establish clear communication gateways between ACO/PCP's and CSA's. Staff training projects will encompass CSA staff receiving additional training in strength based practice models that foster the wraparound process. Some examples include motivational interviewing or collaborative problem solving. Training may occur to CSA staff and also to ACO/PCP partners and training needs will be developed based upon needs identified at that time to foster collaboration between PCP/ACO and CSA. All of these ideas will continue to be further developed upon RFR funding.

6.4 A.3. The Workforce Development Project will be ongoing and extend beyond the DSRIP contract. The planned activities include convening an internal training and workforce development committee, establishing training priorities and working with the other CSAs to plan regional trainings. The training agenda will address the needs identified in the CSA Development Plan and will be designed to meet the quality goals established in this RFR.

6.4 A.4 The CCBC CSA will meet the following deliverables as a result of this project:

- Improved access to ICC services for children with SED in the Attleboro-Taunton area;
- Greater fidelity to the Wraparound Principles as measured by the Wraparound Fidelity Index, specifically improved use of Natural Community Supports;
- Improved competency among CSA staff in integrating primary care information into the CSA Care Plan; and
- Increased involvement of PCCs in the Care Planning process and their embracing of a strength-based, family-centered, culturally sensitive approach to Care Planning.

6.4 A.5 DSRIP funding totaling $26,289ver the five year period will be used on the following to execute the Workforce Development project and an explanation of how each investment will support the execution of the project goals is explained below:

Training and Collaboration Events: Budget for training and collaboration events with area pediatricians, MCOs and ACO representatives to achieve the goal of coordinating strength-based care planning by the CSAs with pediatricians, ACOs and MCOs. CCBC's CSA is committed to collaborate with at least one other regional CSA provider to work with pediatricians, MCOs and AOCs in our region. The goal of these projects is to strengthen CSA capacity to work with pediatricians and to engage pediatricians more actively in the care planning process and to support a regional conference with pediatricians and ACO and MCO representatives. Additionally the goal is to promote the strength-based approach to care coordination with pediatricians and improve skills and competencies of CSA workforce to work with families, help them access primary care, and access natural community supports as part of the care planning. Budget $6,500.

Recruitment will primarily be used to recruit and hire a part-time Data Analyst / Quality Management employee who will be supporting the Operational Infrastructure project; additionally funds will be utilized to hire additional staff needed to complete requirements of the CSA. Recruitment will be a continuous effort for the CSA as it is expected that we will need to replace staff throughout the budget years. Budget $19,787.

Staff Training the training necessary during the PBP will be completed internally by CCBC staff, therefore the only type of reimbursement necessary is salary replacement which is not allowable under DSRIP therefore the training line is being removed. .

6.4 A.6 CCBC has a fully staffed CSA program including a Program Director. She will oversee implementation of these projects and will be the liaison to the other CSAs and to the MCOs and

ACOs and individual PCC offices. The CCBC Chief Operating Officer is responsible for all training programs within CCBC.

6.4 A.7 As described in Section 6.4 A.5 all of the funds for the Workforce Development project will be used in CCBC's Attleboro-Taunton CSA to be able to develop additional training and collaboration with ACO's, PCP's and MCO's, recruitment efforts and newly developed staff training. All of these initiatives will be designed to increase the competencies of the CSA staff as discussed in our CSA Development Plan and to support the goals of this RFR.

6.4 A.8 The internal evaluation of this project will rely on several measures:
Note: the timeframe to show improvement in these measures will BP2. The baseline will be established for 2017 program operations with additional data collected during calendar year 2018.

- Number of staff participating in the training topics; CCBC will train all 22 staff
- Improvements in competency of staff in skills for accessing natural community supports as part of their work with children and families;
    - Staff will improve skills demonstrated by engaging natural community supports as a component care planning for children and families as documented in the EMR.
    - All 22 staff will improve their competencies
    - The Program Director and Program Supervisors will evaluate the skill improvement. The Data Analyst will conduct spot checks of the EMR to validate the documentation of natural community supports in the Care Planning field of the EMR.
    - Staff will also improve skills in transitions of care by including additional notes that reflect the family's access of natural community supports as part of the transition, as documented in the EMR and validated by their supervisor.
- Increase in the number of PCCs participating in Care Planning meetings;
    - CCBC will engage 15 PCCs in care planning process in 2018. Their participation will be documented in the minutes of team meetings, in progress notes, and in correspondence between PCCs and the CSA staff.
    - CCBC will seek to increase the number of PCC's participating in subsequent years.
    - CCBC will install 10 Zoom Video Conferencing software programs in PCC offices to facilitate their participation and increase by five in BP 3.
    - The Data Analyst will track the installations of the software and verify when it is being used by the office of the PCC.

- Increase in the Wraparound Fidelity Index scores of CCBC from 2017 to 2018;
    - Beginning with the baseline from most recent score provided to CCBC in August, 2017. CCBC will improve its score on Natural Community Supports as measured on the TOMS and WIFI-EZ by 3% by the end of BP 2, in December, 2019. The evaluation is conducted by the National Wraparound Initiative. Natural Community Supports are one of six dimensions of Wraparound Fidelity measured.

- Improved ranking on CCBC's CSA Development Plan in subsequent reviews; and
    - The ranking is determined by the MCOs according to many criteria and goals are set each year to design improvements. Success is measured by the MCOs based on monthly meetings and aggregate of the work of the provider.
    - CCBC is not privy to the specific criteria used to evaluate the programs.

- Lower turnover and lower vacancy rate in CSA workforce.
    - CCBC has recently collected information on turnover rates and vacancies. CCBC will reduce turnover by 5% in 2018 and reduce the vacancy rate by 3%. There are new resources in CCBC who are helping track these measures.

6.4 B. Project Team Description for Workforce Development:
6.4 B.1 ATTACHMENT–SEE THE ATTACHED CSA ORGANIZATIONAL CHART

6.4 B.2 The staff who will oversee this project include:

- Director of CSA;
- Compliance and Quality Management Coordinator;
- Chief Operating Officer, who oversees all training for CCBC;
- eHana Program Manager for the collection and reporting of quality measures included in this RFR.

JOB DESCRIPTIONS FOR THESE POSITIONS ARE ATTACHED

6.4 B.3 There will be no new staff associated with the Workforce Development Project.

6.3 B.4 Roles and responsibilities of the project team:

Staff Position	**Roles and Responsibilities**
CSA Program Director	Responsible for all CSA Program activities, including quality improvement, contracting with MCOs; relationships with ACOs and PCCs; and staff development, including training resources inside CCBC and external training.
Compliance and Quality Management Coordinator	Oversees all CCBC quality of care measurement and reporting.
Chief Operating Officer	Responsible for all day-to-day program operations of CCBC; oversees CCBC training program and allocation of training resources to each CCBC program.
eHana Program Manager	Oversees implementation of eHana across CCBC programs; oversees implementation of CSA EHR, including problem-solving with eHana, training of CSA staff, and developing reporting formats on CSA activities related to the CCBC CSA DSRIP Plan.

6.4 B.5. The CSA Program Director will be responsible for managing the Workforce Development Project. She will receive support from the eHana Program Manager, the Director of Quality Management, and the Chief Operating Officer in meeting the goals of the CSA DSRIP Plan as submitted. She will orient staff and develop training on the documentation of data needed to report on the Quality Slate in Appendix A and other quality measures for this CSA DSRIP Plan.

6.4 A. Project Description:
6.4 A.1 OPERATIONAL INFRASTRUCTURE

6.4 A.2 The Operational Infrastructure Project will support the RFR Goals of "Fostering strong integration with ACOs and primary care providers" and "Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families." The Operational Infrastructure Project will also support the CSA's Goal #2 in our development plan to "Increase skill sets of CSA staff to help families to transition out of the CSA to community-based natural supports and ongoing outpatient behavioral health services." An additional goal of the Operational Infrastructure Project is to improve the capacity of CCBC's CSA to document and report on program activities related to quality of care, specifically the Quality Slate in Appendix A. The project will have five components, including 1) hiring of a Data Analyst/Quality Manager staff person at .5 FTE; 2) establishment of an internal data collection and reporting format; 3) development of reports to ACOs and MCOs on key measures of quality and access; 4) improvement of CCBC's analytic capability related to Total Cost of Care in conjunction with the ACO program model; and 5) installation of capacity for a HIPAA compliant secure video conferencing process between CCBC and pediatrician offices that are part of the ACO networks in the Attleboro-Taunton area.

6.4 A.3 The Operational Infrastructure project will be ongoing and extend beyond the DSRIP contract. The planned activities include: hiring the Data Analyst/Quality Manager; developing data collection and reporting formats on quality measures; developing key measures with PCCs, ACOs and MCOs; training and supporting the CSA staff on documentation and sharing reports with them; using the reports to develop quality improvement goals related to CCBC's Development Plan; closer alignment with the ACO operations; and installing a secure video conferencing capacity between CCBC and ACO pediatricians' offices.

6.4 A.4 The CCBC CSA will meet the following deliverables as a result of this project:

- Improved ability in reporting on quality of care of the CSA to ACOs, MCOs and MassHealth;
- Greater fidelity to the Wraparound Principles as measured by the Wraparound Fidelity Index, specifically improved use of Natural Community Supports;
- Stronger alignment with participating PCCs and ACOs in care coordination and care management activities; and
- Increased involvement of PCCs in the Care Planning process via secure video conferencing.

6.4 A.5 DSRIP funding totaling $164,217 over the five year period will be used on the following to execute the Operational Infrastructure project and an explanation of how each investment will support the execution of the project goals is explained below:

- Hiring of a .5 Data Analyst/Quality Manager to support CSA in meeting targets in Quality Slate and achieving goals in CSA Development Plan. Hiring of Data Analyst/Quality Manager on February 1 to orient the person to the CSA, Quality Slate and begin to work with CSA staff to develop methods of collecting and reporting data in eHana. The goal is to achieve the targets in the Quality Slate and meet or exceed the goals in the CSA Development Plan. Annual Salary of $50,000 plus 24% tax and fringe. Budget $152,417 (.50 FTE).
- Outreach and collaboration with PCCs and ACOs on sharing reports that identify gaps and demonstrate best practices leading to reduced Total Cost of Care and improved health outcomes; and
- Installation of secure teleconferencing capacity between CCBC and pediatrician offices that are part of ACOs in the Attleboro-Taunton area. Budget $11,800

6.4 A.6 CCBC has a fully staffed CSA program including a Program Director who will oversee implementation of these projects and will be the liaison to the other CSAs and to the MCOs and ACOs. CCBC's Compliance and Quality Management Coordinator will supervise the .5 Data Analyst/Quality Manager. The CCBC Chief Operating Officer is responsible for all training programs within CCBC. The eHana Program Manager will be responsible for ensuring communication via the Mass HIway.

6.4 A.7 As described in Section 6.4 A.5 all of the funds for the Operational Infrastructure project will be used in CCBC's Attleboro-Taunton CSA to be able to focus on the CSA Development Plan goals by hiring the .50 Data Analyst/Quality Manager, focusing on our Quality Improvement plan and the quality measures in the Quality Slate and the installation of the secure video teleconferencing with PCC's in the area. All of these initiatives will be designed to increase the competencies of the CSA as discussed in our CSA Development Plan and to support the goals of this RFR.

6.4 A.8 The internal evaluation of this project will rely on several measures. Because these are all enhancements to the existing system, the baseline period is calendar year 2017:

- Full capacity to share information on CSA activity to other providers via the Mass HIway as documented by a successful file exchange with three PCC offices by 5/15/2017 and expanded to ACO-partner facilities by 12/310/2018;
- Documenting and reporting on quality measures contained in Appendix A, the Quality Slate as documented by a timely submission of completed reports to the MCOs by the end of BP 1 and again at the end of BP 2;
- Establishing two-way communication with pediatricians via secure video conferencing to increase their participation in the Wraparound Care Planning process. See Workforce Development for evaluation measures. 10 pediatricians will have video conferencing installed in BP 1 and 15 by BP 3, with participation documented in the family's EMR; and

- Reducing the administrative burden of CSA staff for documentation of CSA activity and tracking of quality and access measures. The reduction will be measured via a staff satisfaction survey on how the EMR has affected paperwork and other administrative burdens. The survey will be administered in June, 2019.
-

6.4 B. Project Team description for <u>Operational Infrastructure</u>
6.4B.1 ATTACHMENT – SEE THE ATTACHED CSA ORGANIZATIONAL CHART

6.4 B.2 The staff who will oversee this project includes:

- Director of CSA;
- Compliance and Quality Management Coordinator;
- eHana Program Manager for the collection and reporting of quality measures included in this RFR; interface with Mass HIway.

JOB DESCRIPTIONS FOR THESE POSITIONS ARE ATTACHED.

6.4. B.3 CCBC is proposing to add a .5 FTE Data Analyst/Quality Manager who will assist the CSA Program Director and CCBC Compliance and Quality Management Coordinator in the implementation of new quality measures and reporting format that will be part of the CSA EHR for reporting. This position will complement the .5 FTE that CCBC has proposed for the Behavioral Health Community Partner proposal that covers Taunton, Attleboro and Brockton. This person will also oversee the implementation of CCBC's eHana EHR and Mass HIway connection as related to reporting on client activity and quality of care data.

6.4B.4

Staff Position	**Roles and Responsibilities**
CSA Program Director	Responsible for all CSA Program activities, including quality improvement, contracting with MCOs; relationships with ACOs and PCCs; staff development, including training resources inside CCBC; and external training.
Data Analyst/Quality Manager	Develops measures for quality metrics in CSA DSRIP RFR; ensures staff competency in tracking measures; develops reports on measures; and develops reports to PCCs and ACOs on client activities.
Compliance and Quality Management Coordinator	Oversees all CCBC quality of care measurement and reporting.
Chief Operating Officer	Responsible for all day-to-day program operations of CCBC; oversees CCBC training program and allocation of training resources to each CCBC program.
eHana Program Manager	Oversees implementation of eHana across CCBC programs; oversees implementation of CSA EHR , including problem-solving with eHana, training of CSA staff, and developing

	reporting formats on CSA activities related to the CCBC CSA DSRIP Plan; oversees connection of CCBC to Mass HIway; and installation of telehealth technology between CCBC and ACO-affiliated pediatricians.

6.4 B.5 The CSA Program Director will be responsible for managing the Operational Infrastructure project. She will receive support from the eHana Program Manager, the Compliance and Quality Management Coordinator, and the Chief Operating Officer in meeting the goals of the CSA DSRIP Plan as submitted. She will orient the .5 Data Analyst/Quality Manger to the CSA program and work with the Data Analyst/Quality Manager to establish key measures and reports for aligning with the goals of PCCs, ACOs and MCOs. The CSA Program Director will work with the Vice President of Child and Family Services, the COO and the CEO to strengthen relationships with the ACOs. The CSA Director will also oversee development of reports on the Quality Slate in Appendix A.

6.4 A. Project Description:
6.4 A.1 TECHNOLOGY
6.4 A.2 The Technology Project will support the RFR Goals of "Fostering strong integration with ACOs and primary care providers", "Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families" and "Improving timely access to ICC services for children eligible to receive ICC and their families". At the same time the Technology Project will support the CSA's Goal #2 in our development plan to increase skill sets of CSA staff to help families transition out of the CSA to community-based natural supports and ongoing outpatient behavioral health services. Additionally the Technology Project has the goal to improve the ability of the CSA to gather and share information with Primary Care Clinicians, ACOs and MCOs to coordinate care, enhance access to primary care and specialty care services and to reduce reliance on more restrictive services such as Emergency Department and Inpatient Services.

In this project, CCBC will work with its electronic health record (EHR) and software developer, eHana and other regional CSAs that use eHana to install customized EHR software to collect important information on the child and family that will inform family-centered, recovery-oriented treatment planning. The installation of the software will also include CCBC's ability to connect with the Mass HIway to facilitate sharing with PCC's for their approval of the treatment plan and to update them when a child or family's circumstances change and additional interventions are needed. Another feature of the software implementation will improve the efficiency of submission of CANS information and CANS reporting by CCBC to MassHealth. The EHR will function on portable electronic devices (laptops, tablets, IPads or Smart Phone) for use by the Intensive Care Coordinators with children and families. This project also includes funding for these devices in Project Year 1. The module will also allow for the collection of data related to the quality metrics in the Quality Slate in Appendix A.

6.4 A.3 Development and implementation of the CSA will commence upon award of the RFR and will conclude at the end of the Budget Preparation period on May 31, with continued

problem-solving and adjustments continuing in Program Year 1, December 31, 2018. CCBC will allocate $$34,000 to this project to pool resources with other CSAs in the Southeast (BAMSI, Bay State Human Services, and JRI) who use eHana EHR for a care management module.

The EHR will be customized for the CSA and ICC programs to enhance the goals of the DSRIP ACO program, ensuring fidelity to principles of the wraparound model. The EHR will allow for family signatures and data entry, highlighting connection to natural community supports, family's choice of members of the care team, identified primary care issues, and a field for approval of the care plan by the PCC or his/her designee. The majority of funds for Year 1 will be used for purchase and installation of mobile devices for ICC staff.

6.4 A.4 The deliverable for this project will be a fully installed EHR that is integrated into CCBC's existing eHana EHR, is connected to the Mass HIway, facilitates information sharing with PCCs, ACOs and MCOs, and has the capacity to improve efficiency of submission and reporting on CANS data and tracking and reporting on the quality metrics that are part of the DSRIP program and Wraparound Fidelity Index. The deliverable includes enhanced capacity for secure information sharing with ACOs and PCCs via the ICC's mobile device. Another deliverable is the capacity to collect information for reporting on the Quality Slate in Appendix A.

6.4 A.5 DSRIP funding of $93,000 over the five year period will be used on the following to execute the Technology project and an explanation of how each investment will support the execution of the project goals is explained below:

1) Provide Funds to utilize an **Electronic Health Record for CSA** clients. CCBC will implement an Electronic Health Record for all clients of CSA. Budget $20,000;
2) Funds for the customization of the required data sets in the EHR to comply with the required **care management reporting.** Budget $10,000.
3) Funds for development of **Care Management Data Sets** installation, implementation and connection to **Mass HIway** in advance of implementation. Budget $11,000;
4) **WRAP Documentation Development** a strengths based documentation module. (shared) Budget $8,000;
5) **CANS Interoperability Project** to enable more efficient date collection and reporting. (shared) Budget $6,000;
6) **CSA Quality/Accountability Measure Reporting** to implement data tracking, dashboarding and reporting necessary to support Quality Measure capture, management and submission. (shared) Budget $5,000;
7) **Professional Services** including Project Management, Business Analysis, Training, Development and Support for our vendor to develop and program the necessary systems as describe above. Working with CCBC to allow for specific needs regarding analysis, training and support. Budget $19,000;
8) **Electronic Devices** IPads, Tablets and Smartphone will be utilized to work in the electronic environment. These devices we will purchase during the prep period to allow for installation before April 1 to allow for training for the new software. Budget $12,000.

The goal is to reduce the administrative burden on CSA staff, provide timely reports to other members of the care planning team for review and approval, develop methods of aggregating and reporting on the CSA population, including the integration of primary care and behavioral health, and identify clinical pathways to recovery for children and families.

*(shared) Categories marked as shared are those items that will be a shared costs by CSAs in the state that utilize the same Electronic Health Care vendor. Our shared vendor is developing systems and the cost will be shared by the participating CSAs.

6.4 A.6 The CCBC eHana Program Manager, the CCBC IT department, the CCBC CFO, and the Director of the CSA will be responsible for the implementation of this project.

6.4 A.7 As described in Section 6.4 A.5 all of the funds for the Technology project will be used in CCBC's Attleboro-Taunton CSA to be able to focus on the CSA Development Plan goals by developing a CSA Electronic Health Record with a Care Management Reporting; access to the EHR through mobile technology for staff and professional support of this technology. All of these initiatives will be designed to increase the competencies of the CSA as discussed in our CSA Development Plan and to support the goals of this RFR.

6.4 A.8 Deliverables and key milestones include:
Installing the final prototype of the Care Management software by 4/1/2018;
Verifying capacity to meet Reporting requirements in software tests by 5/15/2018;
Installation in CCBC EHR format by 5/1/2015;
Testing of the reports for data entry, reporting and data exchange by 5/31/2018;
Training of ICC staff and supervisors between 4/1 and 5/31/2018;
Full implementation of data entry by 6/1/2018;
Information exchange with PCCs, MCOs and ACOs via the Mass HIway as measured by successful test files by 10/1/2018;
Generation of reports related to quality goals and aggregate data on the CSA population measured by acknowledgment by MasHealth of receipt of completed reports by 3/1/2019.

6.4 B.1 Project Team Description for Technology:
6.4 B.1 ATTACHMENT – SEE THE ATTACHED CSA ORGANIZATIONAL CHART
6.4 B.2 List of current Staff Involved with the Project

Title	Job Description	Qualifications
Chief Executive Officer	Directs and manages overall operations of organization, including implementation of new programs.	Programmatic and Fiscal experience in community behavioral health.
Chief Operating Officer	Responsible for operations and implementation.	Experience in program management and project management of community behavioral health.
Chief Financial Officer	Oversees financial operations, budgets, implementation of billing and reimbursements	Accounting, budgeting, billing and revenue collection experience with third parties

	for new programs, ensures integrity of programs.	and state contracts.
eHana Program Manager	Responsible for operations of eHana EHR, training of staff, problem solving with vendor, and implementation of updates to eHana system.	Experience in human services software development and implementation, including EHRs.
CSA Program Director	Directs CSA Program, i.e. recruit and train manage staff, manage contracts with MCOs; report on quality management activities; ensure fiscal stability of CSA and other CBHI programs.	Experience with SED; knowledge of wraparound model of care; independently licensed clinician.

6.4 B.3 CCBC will implement this project with existing staff.

6.4 B.4 The roles and responsibilities of CCBC's Project Team for Software Installation and connection to Mass HIway:

Title	**Roles and Responsibilities for Implementation of eHana Electronic Health Record**
Chief Executive Officer	First point of negotiation with eHana. Final point of approval for eHana contract and program budget.
Chief Operating Officer	Supervises implementation of EHR . Coordinates among CFO, CSA Director, eHana IT Manager, and linkage to ACOs.
Chief Financial Officer	Coordinates implementation of eHana with billing and program management of CSA. Ensures documentation is consistent with billing protocols.
eHana Program Manager	Principle CCBC contact with eHana on implementation of CSA EHR . Oversees training of CSA staff. Initiates problem solving with eHana and installs updates as needed.
CSA Program Director	Organizes staff for implementation of EHR. Provides content expertise to eHana on key components of module, development of reports and information exchange with PCCs, ACOs and MCOs.

6.4 B.5 The CEO, COO, CFO and IT Manager will meet monthly to assess progress on this project. The CSA Director will include project updates on their agenda for regular CSA monitoring meetings with the MCOs, where the CSA Development Plan is reviewed and updated.

6.4 C. Implementation Plan and Timeline (one timeline for all three projects)
Below are key deliverables for EHR **Project:**

	Project 1 –	**Project 2 –**	**Project 3 –**

Time Period	Workforce Development	Operational Infrastructure	Technology
January 2018	Development of training agendas.	Develop job description for Data Analyst/Quality Manager; initiate recruitment activities; develop purchasing specifications for secure video conferencing.	Design and planning for software. Down payment to eHana with contractual deliverables for Installation on April 1, 2018.
February 2018	Development of training agendas.	Post position; conduct initial interviews for data analyst. Complete purchasing specifications for secure video conferencing.	Design and Planning. Develop sharing via Mass HIway
March2018	Design of training agendas; set schedule for trainings.	Conduct second round of interviews; make offer; issue RFR for secure video conferencing	Design and Planning. Develop sharing via Mass HIway
May 2018	Begin internal and external trainings;	Data analyst begins; select bidder for secure video conferencing; and complete contract negotiations.	Design and planning; develop sharing via Mass HIway; and initial meetings with ACOs and pediatricians.
June 2018	Continue internal and external trainings	Data analyst participates in installation of software around quality slate; install secure video conferencing.	Installation of software; training for CSA ICC staff; work with ACOs and affiliated PCCs to share information via Mass HIway; initial purchase of mobile devices for use with the EHR .
August 2018	Begin internal and external trainings	Data analyst oversees collection of data for quality slate.	Second round purchase of IPads/tablets/smart phones for ICC staff; implementation per

			ACO model; problem-solving with eHana; share care plans with pediatricians for approval.
September 2018	Continue trainings.	Data analyst oversees collection of data for quality slate; data analyst reports on initial quality activity to Director of Quality Management and develops reports for ACOs, MCOs and MassHealth.	Generation of aggregated reports related to ICC population; continued implementation; problem-solving with eHana; reporting and information sharing with PCCs, ACOs and MCOs.
October 2018 ongoing	Continue trainings	Data analyst oversees collection of data for quality slate; data analyst reports on quality activity to Compliance and QM Coordinator and reports to ACOs, MCOs and MassHealth on Quality slate.	Continued implementation and problem-solving with eHana; reporting and information sharing with pediatricians, ACOs and MCOs.
January – March 2019	Continue trainings	Data analyst oversees collection of data for quality slate; data analyst reports on quality activity to Compliance and QM Coordinator and reports to ACOs, MCOs and MassHealth on Quality slate.	Purchase of IPads, smartphones and tablets as necessary; implementation of software upgrades as published by eHana; problem solving as needed.
April – June 2019	Continue trainings	Continued collection and reporting.	Implementation of software upgrades as published by eHana; problem solving as needed.
July – September 2019	Continue trainings	Continued collection and reporting.	Implementation of software upgrades as

			published by eHana; problem solving as needed.
October – December 2019	Continue trainings; publication and distribution of video.	Continued collection and reporting.	Implementation of software upgrades as published by eHana; problem solving as needed.
January – March 2020	Continue trainings; publication and distribution of video.	Continued collection and reporting	Implementation of software upgrades as published by eHana; problem solving as needed.
April – June 2020	Continue trainings; publication and distribution of video.	Continued collection and reporting.	Implementation of software upgrades as published by eHana; problem solving as needed.
July – September 2020	Continue trainings; publication and distribution of video.	Continued collection and reporting.	Implementation of software upgrades as published by eHana. Problem solving as needed.
October – December 2020	Continue trainings; publication and distribution of video.	Continued collection and reporting.	Implementation of software upgrades as published by eHana; problem solving as needed.
January – March 2021	Continue trainings; publication and distribution of video.	Continued collection and reporting.	Implementation of software upgrades as published by eHana. Problem solving as needed.
April – June 2021	Continue trainings; publication and distribution of video.	Continued collection and reporting.	Implementation of software upgrades as published by eHana; problem solving as needed.
July – September 2021	Continue trainings; publication and distribution of video.	Continued collection and reporting.	Implementation of software upgrades as published by eHana; problem solving as needed.
October – December 2021	Continue trainings; publication and distribution of video.	Continued collection and reporting.	Implementation of software upgrades as published by eHana;

			problem solving as needed.
January – March 2022	Continue trainings; publication and distribution of video.	Continued collection and reporting.	Implementation of software upgrades as published by eHana; problem solving as needed.
April – June 2022	Continue trainings; publication and distribution of video.	Continued collection and reporting.	Implementation of software upgrades as published by eHana. Problem solving as needed.
July – September 2022	Continue trainings; publication and distribution of video.	Continued collection and reporting.	Implementation of software upgrades as published by eHana; problem solving as needed.
October – December 2022	Continue trainings; publication and distribution of video.	Continued collection and reporting.	Implementation of software upgrades as published by eHana; problem solving as needed.

6.4 D. – Budget Report and Budget Narrative

6.4 E. Sustainability

CCBC recognizes the limit of the DSRIP funding for the CSA and the decreasing reimbursements over the term of the five-year contract. We expect a smooth transition into the ACO model and have designed a number of strategies to sustain these projects and support the ACO model as an active partner:

- Increased volume of referrals will allow for the administrative allocation to cover a broader range of infrastructure, including purchase of equipment and paying for maintenance costs of the EHR Software.
- Moving CSA reimbursement to a Day Rate will allow for efficiencies of documentation and greater retention of CSA staff.
- Improved working relationships with PCCs around care planning, timely information sharing and more effective clinical interventions will lead to improved client outcomes, reduced total cost of care and enhanced value of the CSAs as Care Managers. CCBC will work with the ACOs to contend for a share of the MCO-contracted Care Management resources to be allocated to CCBC based on achievement of improved quality of care, health outcomes, and reduced total cost of care for some of the most costly and vulnerable members of the ACOs that are under 21.

- Gradual implementation of alternative payment mechanisms will reduce administrative burdens on CCBC and allow administrative resources to be shifted to maintenance of the EHR .
- Shifting of some of the resources allocated to training and technical assistance from CCBC to the ACOs with affiliated PCCs engaged in the CSA and SED populations.

Section 6.5 Coordination with ACOs, MCOs, and Primary Care Providers

6.5 A. Bidirectional communication between the Bidder and pediatric practices:
The CCBC CSA has established relationships with over 20 pediatric practices in the Attleboro-Taunton area. On occasion, the ICC has arranged for Care Planning meetings to be held on site at these pediatric offices affording the pediatricians greater ability to participate in Care Planning meetings. While this is a strong foundation, CCBC will implement their DSRIP Participation plan with the goal to improve bidirectional communication with pediatric practices.

First, CCBC CSA will complete the cataloguing of PCC and pediatric practices to determine the type of working relationship and rank pediatric practices by no, low, moderate and strong working relationships. The CSA Director will then reach out to the practices with low and no working relationships to identify their needs and to share the DSRIP Participation Plan with them.

Second, the CSA will work with ACOs to have the ability to share information via the Mass HIway and develop protocols to share information so that pediatricians can approve the Care Plan for their clients on a timely basis once sent to them by the CSA. CCBC already has a commitment from the Steward Health System to collaborate on information sharing and timely approval of care plans for the adult population served by the Behavioral Health Community Partners and to provide real-time notification to CCBC when CCBC clients, including clients of the CSA, are admitted to Steward Emergency Departments or Inpatient Medical units.

Third, CCBC will explore with the pediatric practices and the ACOs the feasibility of installing secure video conferencing capacity for pediatricians or their designees to participate remotely in care planning meetings convened by the ICCs. CCBC has proposed a budget for secure video conferencing as part of the DSRIP participation plan and hopes to work with the ACOs to support a broader installation of secure video conferencing capacity across their networks, including in hospital emergency departments.

A specific outcome of this increased bidirectional communication will be to provide more timely intervention and support to families in crisis, convene on a more timely basis all of the parties with a working knowledge and role in serving the child and his/her family, and share critical information to develop better care plans for children with complex medical and behavioral health conditions.

6.5 B. Referral management protocols for follow-up and informational sharing:
Per CSA performance standards, CCBC works with children and families to sign release of information forms at the time of the initial assessment to allow for sharing of information with the pediatricians. The follow up includes a range of communication based on the individualized

needs of the child and family. They include encouragement of the pediatrician to use MCPAP when prescribing psychotropic medications, invitations to participate in care planning meetings, sharing of clinical assessments and care plans with the pediatrician, requests from the pediatrician for most recent physical, and updates from both parties following any acute episode of primary care or behavioral health such as an inpatient admission or use of the emergency department.

The enhanced electronic communications will include capacity for referrals for timely appointments and requests for specialty referrals, such as a psychopharmacologic evaluation by CCBC, or referral to a specialty medical provider for children with complex medical conditions. CCBC will measure the impact of improved referral management through the quality improvement process.

6.5 C. Team-based treatment planning in collaboration with pediatric practices:
The implementation of secure video conferencing will increase the opportunities of the pediatric practices to participate in care planning meetings convened by the ICCs, in addition to the option of convening the care planning meeting at the offices of the pediatric practice.

The improved communication will allow pediatricians, CSA, CCBC outpatient providers and representatives from the ACO affiliated with the pediatrician to review the child's recent treatment history and service utilization to identify gaps in care, celebrate successes in transitions of care and identify other opportunities to strengthen transitions and improve outcomes – all key tactics to achieve the Triple Aim.

These interventions will be an important resource for children with co-occurring chronic and complex medical conditions such as asthma and diabetes with severe emotional disturbances. These children require more involved care planning and clinical review so that interventions, especially prescribed medications, complement rather than contraindicate each other. The goal of the CSA is to foster a culture that promotes a strength-based and family-centered approach to families in conjunction with the medical model. CCBC has had initial success in convening care planning meetings, but recognizes the challenge to expand care planning to other pediatricians who are less familiar with the Wraparound model of care.

Another strategy to facilitate team-based planning is to involve pediatricians and their designees in the regional training forums proposed in the Workforce Development section of section 6.4. CCBC and other providers will seek to have pediatricians participate in these trainings directly, via secure video conferencing technology or in recorded training videos.

6.5 D. Timely access to ICC services:
CCBC has a documented track record of timely access to care as evidenced in the most recent Development Plan report that showed zero (0) families on the waiting list for ICC services. CCBC does expect the DSRIP Participation Plan to result in greater exposure to PCCs and their affiliated ACOs and MCOs operating in the Attleboro-Taunton area and thus an increase in referrals and overall volume of CSA services. The CSA Director will monitor the increase in referrals and ensure a full complement of staff to provide timely access to services.

6.5 E. Connections to social services:

CCBC has developed a long-standing commitment to developing collaborative relationships with other social service providers in the Attleboro-Taunton area that benefit families served by the CSA. The commitment of CCBC`s CSA to other agencies has developed and strengthened since the onset of ICC services in 2009. The CSA maintains its monthly Systems of Care meetings with a broad range of attendees, including law enforcement, local Department of Children and Families (DCF) representatives, local schools, other behavioral health providers, Department of Mental Health (DMH) Area Office representatives, and pediatric offices. The CSA will extend invitations to ACO representatives and their affiliated hospitals, including Steward Health Care's Morton Hospital and Sturdy Memorial's pediatric service.

The CSA maintains visibility through participation in the interagency collaboration meeting, the DCF Taunton Children's area board, the Bristol County Juvenile Drug Court Advisory Committee, monthly Systems of Care meetings and hosting of an annual resource fair where local social service providers are invited to provide information to CSA families.

CCBC`s organizational culture supports collaboration with social services in the local community and the positive impacts of the activities described above will continue to expand as the CSA develops a stronger role with ACOs.

CSA Budget Report

Child & Family Services, Inc.

Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites	1	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate	NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)	104	114	120	126	132	138	
Estimated Funds	$ 93,696.00	$ 79,800	$ 50,400	$ 37,800	$ 34,848	$ 16,560	**$ 313,104**
At- Risk Withhold Rate			5%	10%	15%	20%	
Withhold			$ 2,520	$ 3,780	$ 5,227	$ 3,312	**$ 14,839**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 93,696.00	$ 79,800	$ 47,880	$ 34,020	$ 29,621	$ 13,248	**$ 269,394.00**

Investment Projects	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Project 1 Name: *Workforce Development*							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Goal 3:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ 500	$ 1,000	$ 500	$ -	$ -	$ -	$ 2,000
Training Expenses	$ 13,703	$ 8,900	$ 2,500	$ 1,000	$ 500	$ -	$ 26,603
Retention Expenses	$ -	$ 500	$ -	$ -	$ -	$ -	$ 500
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 1 Total	$ 14,203	$ 10,400	$ 3,000	$ 1,000	$ 500	$ -	$ 29,103
Project 2 Name: *Operational Infrastructure*							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Goal 3:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ 33,774	$ 41,440	$ 39,648	$ 33,021	$ 30,919	$ 15,060	$ 193,862
Other Operational Expenses	$ 7,203	$ 8,100	$ 1,500	$ -	$ -	$ -	$ 16,803
Project 2 Total	$ 40,977	$ 49,540	$ 41,148	$ 33,021	$ 30,919	$ 15,060	$ 210,665
Project 3 Name: *Technology*							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Goal 3:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ 3,750	$ 2,500	$ 500	$ -	$ -	$ -	$ 6,750
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ 26,309	$ 10,100	$ 1,200	$ 300	$ 300	$ -	$ 38,209
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 3 Total		$ 30,059	$ 12,600	$ 1,700	$ 300	$ 300	$ -	**$ 44,959**
Total Project Costs		$ 85,239	$ 72,540	$ 45,848	$ 34,321	$ 31,719	$ 15,060	**$ 284,727**
Indirect Costs/ Administrative Overhead Rate	10%	$ 8,457	$ 7,260	$ 4,552	$ 3,479	$ 3,129	$ 1,500	**$ 28,377**
Investment Projects Total		$ 93,696	$ 79,800	$ 50,400	$ 37,800	$ 34,848	$ 16,560	**$ 313,104**

CSA Budget Report - Budget Narrative Prep Budget Period

CSA Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name: Workforce Development
DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care planning,*
2 *(3) Improving timely access to ICC services for children eligible to receive ICC and*
3 *(1) Fostering strong integration with ACOs and primary care providers for ICC-Eq*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Operational Infrastructure
DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E.*
2 *(3) Improving timely access to ICC services for children eligible to receive ICC an*
3 *(2) Strengthening fidelity to Wraparound processes, including the care planning,*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name: Technology
DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E.*
2 *(3) Improving timely access to ICC services for children eligible to receive ICC an*
3 *(2) Strengthening fidelity to Wraparound processes, including the care planning,*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
E H R adaptation/enhancement	$ 3,750.00
Total Development and Adaptation of EHR and Care Management System	$ 3,750.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Our EHR provider, Netsmart,will provide 15 hours of time to work on adaptation/enhancement of our current system to accomodate the requirements of this contract. Currently, our EHR is not designed to collect and report this data. Netsmart will adjust forms to include the quality measures required by this grant, such as prevention and wellness, behavioral health, collection of data from the WIY-EZ, hospital discension/admission and client engagement.

15 hours X $250/hour = $3750

Technology for Service Delivery

Description of Expense	Cost
laptop computers	$ 18,750.00
Ancillary laptop supplies	$ 899.00
2 large screen televisions	$ 3,000.00
secure email	$ 3,300.00
MUMway connection	$ 360.00
Total Technology for Service Delivery	$ 26,309.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Purchase 25 two in one laptop computers for use by 25 CSA staff in the field. 25 X $750 = $ 18,750

Ancillary laptop supplies including a wireless mouse, cases, and cards for each computer

Purchase of 2 large screen televisions to support telehealth conferencing , $1500 each

Secure email for 25 CSA staff, $1100 annually. The annual cost to the agency is $11,000. CSA is allocated 30% of this cost for all staff to have access to secure email.

Mathway connection $360 annually. The annual cost to the agency is $1200. CSA is allocated 30% of this cost for all staff to have access to Mass Hiway.

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:
DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:
DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:
DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:
DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Workforce Development - Prep Budget Period

Project 1 Name: Workforce Development

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Advertisement	$ 500.00
Total Recruitment Expenses	$ 500.00

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Advertisement for newly created position of Integrated Care Liaison. Sponsored ad on Indeed.com for one month.

Training Expenses

Description of Expense	Cost
Integrated care certification course	$ 11,700.00
Advanced Motivational Interviewing	$ 1,200.00
Refreshments	$ 803.00
Total Training Expenses	$ 13,703.00

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Approximately 18 ICC staff will attend integrated care management course with certification. Cost is anticipated to be $650/person. Training will be through Webinar, 3 times per month and includes group supervision for 10 weeks. Total is $11,700.

Training for 30 CSA staff on Advanced Motivational Interviewing techniques. Total is $1,200

Refreshments for these meetings $803 for all sessions.

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 1 Name: Operational Infrastructure

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				-
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary				$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Integrated Care Liaison	$ 48,000.00	1	4	$ 16,000.00
Program Director	$ 61,587.00	0.22	11	$ 12,622.00
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		1.22		$ 28,622.00
Fringe rate		16.0%	Total Fringe	$ 5,152.00
			Total Program Staffing including Fringe	$ 33,774.00

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project

Integrated Care Liaison provides direct connections and relationships with ACO's, PCP's and other community partner.
Marketand advertise program, available for meet and greets.
Coordinate a large kick off event, carry a small caseload as an ICC
Support referral and intake process at the CSA, particularly for complex cases

Program Director 's time spent to develop the DSRIP project, research, ~~grant writing~~ meeting attendance

Other Operational Expenses

Description of Expense	Cost
Marketing and outreach materials	$ 6,603.00
Supplies and other	$ 600.00
Total Other Operational Expenses	$ 7,203.00

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Marketing supplies and outreach materials including:
newspaper: $1200
other publication costs: $500
brochure: $1000
flyers: $500
posters: $250
banners: $378
resource fair giveaways: $1100
refreshments, mileage: $1600
Marketing materials will describe the services provided by the CSA CP . Target audience will include ACO's, PCP's, parents, and other providers such as, schools, outpatient mental health clinics and private practitioners, state departments, etc.
Other supplies include office supplies for new position, business cards, etc

Project 3 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary				$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary				$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary				$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary				$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary				$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate: 10%

Provide a brief description of how the Indirect Cost/Administrative Overhead rate was determined. Indirect costs/ Administrative overhead is approximatley 10% of the project costs. These costs include: indirect IT, HR, Billing and administrative tasks.

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS March 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
1	**Workforce Development Project**	To enhance the quality and integration of care coordination services	01/01/18	12/31/22	**Workforce Development**	Training Expenses	Project Manager will research 2 advanced trainings in Motivational Interviewing and Integrated Care Management to see what options are available (including timeframes, locations, costs, etc) by 3/31/18	Project Manager will email Charline a description of the trainings researched.			Project manager will develop a training plan that will ensure 17 ICC staff get certified in Integrated Care Management and 29 staff complete advanced training in Motivational Interviewing. Plan will be finalized and approved by Board staff by 5/31/18.	Training plan submitted will be approved by board		
2	**Operational Infrastructure Project**	To improve our overall marketing and collaboration with community partners, specifically Primary Care Practices and ACOs	01/01/18	12/31/22	**Operational Infrastructure**	Operation Staffing including Fringe	Human Resources recruitment staff will advertise the Integrated Care Liaison (ICL) position and have interviewed at least 4 candidates by 3/31/18	Project manager will email Charline the name, offer letter, and credential information of the hired employee.			The Integrated Care Liaison (ICL) will have identified 6 out of 13 ACOs and have attended "meet and greet" sessions with them by 5/31/18.	Project Manager will email Charline the agenda and attendance sheets for each meeting.		
3	**Technological Improvements**	To increase the program use of technological advances; make staff more "tech savvy"	01/01/18	12/31/22	**Technology**	Technology for Service Delivery	IT Director will purchase 25 "2-in-1/Hybrid Laptops" by 3/31/18	Project Manager will email Charline an invoice for completed purchases			IT department will host a training for 25 CSA staff on how to safely and appropriately handle/use this equipment by 5/31/18	Project Manager will submit the attendance sheet and statement that training was completed.		

Section 6.2 Executive Summary (3 Pages)

The Community Service Agency (CSA) at Child & Family Services (CFS) is committed to providing the highest quality of care coordination and collaboration to effectively serve our families. We recognize the need for improvements and are committed to the DSRIP program.

6.2 A: The Bidder's current performance on its Development Plan.

Our Development Plan identifies two major goals:

- Improving fidelity scores by increasing youth attendance and involvement in the care planning process, as well as continuing to collaborate and communicate with other key stakeholders such as school and social service systems.
- Ensuring that all pertinent information is available for review by our MCEs to meet medical record standards. CSA staff diligently work on improving our quality of records and documentation which includes scanning documents such as signed releases or consents, assessments and forms, as well as appropriate and timely documentation of progress notes, creation of thorough CSA Assessments with more depth and breadth, and improving consistency with measurable goals on our ICP documents.

6.2 B: Specific examples of strengths and needs of the Bidder.

The CSA at CFS exhibits the following strengths:

- Staff and management team are very well versed in Wraparound. Our supervisory team has longevity in this field and in working in a Wraparound program, with 4 out of the 5 program managers taking part in the CFFC pilot program which introduced and rolled out the Wraparound model to the local area.
- We have culturally/linguistically diverse staff, and can accommodate the following languages and cultures: English, Spanish, Portuguese, Cape Verdean Creole.
- We have only been at capacity twice in 8 years, therefore we have minimal issues with access to service. We do not have a wait list, which means our families receive services in a timely manner. As an agency, we are conscious of the need to anticipate the demands of the community and hire on to accommodate referrals.
- We have improved our transition planning as a program and we are making strides in preparing families for transition using measurable outcomes.
- Our CSA program incorporates feedback from the MCEs into our practice to remedy any issues. Staff are open to constructive criticism and quick to make changes.
- With a focus on marketing our program to private practice clinicians, Pediatric offices, and families, we have worked diligently to increase our enrollment, servicing approximately 40 additional families this past year.

The CSA at CFS remains focused on addressing the needs identified in our Development Plan, as well as what we anticipate needing to complete the identified projects as follows:

- Continue to train staff on writing comprehensive detailed assessments with depth and breadth
- Increased marketing/advertising of our CSA program to create and foster stronger relationships with the ACOs, PCPs, Pediatric Practices and other community partners
- Comprehensive training for all CSA staff on medically complex youth
- Improve our fidelity scores around team member attendance (specifically youth involvement/attendance)

- Enhancement of our current technology and EHR capabilities to appropriately capture all necessary documentation for review by MCEs, as well as accuracy of reporting all information for required Quality Measures
- Increase both parent and Transition Age Youth participation in our local SOC

6.2 C: The Bidder's plans for improving timely access to ICC services.

Currently, the CSA program of CFS meets and exceeds the timely access to ICC service standards. We receive and process referrals, and offer initial intakes within the targeted time frame.

Our plans to focus on marketing and education, especially among PCPs, will help physicians better understand the resources and tools that the CSA can provide, ultimately cutting down on inappropriate referrals and improving efficiency of services rendered. The ability to send secure emails in lieu of faxing or calling physicians, who are challenging to reach by phone, will also improve information sharing between all partners and timely access to ICC services.

With the proposed enhancements to our current EHR, and the addition of new technology geared towards improving communication between care providers, a more streamlined and resourceful referral process will lead to improved timeliness of access to care. Additionally, in pursuit of program goals, we propose to purchase Translation Software that will improve timely access to ICC services and strengthen fidelity to Wraparound processes.

Bilingual CSA staff working with non-English speaking families must revise all documents currently written in English, and translate and recreate the documents into the family's native language to meet cultural and linguistic competencies. Translation Software would relieve this burden of translation efforts from the bilingual staff and free up additional time. Currently, bilingual staff have a reduced caseload due to the extra time required when working with non-English speaking and bilingual families. This reserve of additional time would essentially allow for an increase in staff caseload, which would ultimately aid in improving timely access to ICC services for the program.

6.2 D: The Bidder's plans for improving care coordination, care planning, and care management for ICC-Engaged Members.

The CSA at CFS carefully selected projects that would directly impact improvements in care coordination, care planning, and care management for ICC engaged members in the following ways:

- Creation of an Integrated Care Liaison position (ICL) whose focus will be on strengthening partnerships with the ACOs, PCPs and Pediatric Practices.
- Enhancing the Quality and Integration of Care Coordination by means of Workforce Development Training and Certification for CSA Staff. Intensive Care Coordination requires highly qualified staff with specialized educational training and professional development on constantly evolving methodologies, strategies and healthcare regulations. Identified training would improve staff's ability to provide better care management and wraparound support to clients.
- Technological improvements - Investing in new 2-in-1 Laptops, Skype for Business, Telehealth Conferencing and Translation Software, and adding enhancements to our EHR will increase the number of intakes completed in the field, allow partners and supports

to join meetings via video conferencing, and increase accuracy and record keeping. Utilizing secure E-Mail and Mass HIway connections will increase timely access to ICC services and improve efficiencies in care coordination and care management by eliminating barriers to successful care planning.

6.2 E: The Bidder's plans to improve performance on quality scores and Development Plan goals.

Fidelity Goal/Scores – We will continue to train supervisory staff to administer the TOMS 2.0 in order to recognize what constitutes an "integral member of the team" and capture data needed to rate these indicators for scoring. We will continue to foster relationships with key stakeholders such as local school representatives, DCF workers, and PCPs to ensure that they are appropriately educated on the care planning process and to stress the importance of their participation and attendance at team meetings. Training of direct staff on the importance of youth attendance at their care plans is a key component in utilizing the "youth-guided" principle of Wraparound process will continue.

We plan to use DSRIP funds to improve accessibility for providers and natural supports by utilizing innovative technology such as Telehealth Conferencing, which will allow for integral team members to be present in the room even when distance or access issues arise.

Documentation goal/scores - We continue to train our staff on writing clinically sound and meaningful comprehensive assessments. Training in Integrated Care Management, Motivational Interviewing, and Chronic Medical Needs will allow us to better encompass all the needs of the client into these assessments. We will ensure that all relative documentation can easily be found in the EHR with advances in technology such as secure email and connections to the Mass HIway. This will allow for quicker access to medical records from PCPs, educational documents from the school system, and treatments plans from other clinical providers.

6.2 F: The Bidder's plans for improving coordination with pediatric primary care and other physical and behavioral health care providers across the care continuum for youth.

With the creation of a new Integrated Care Liaison (ICL) position, we will foster new and strengthen old relationships with pediatric PCPs. We plan to have a large marketing event to introduce the ACOs, PCPs, and Pediatric Practices to the CSA providers in the area, and to increase networking opportunities with and among collaborative partners. The liaison will also coordinate ongoing education for the PCPs around Wraparound and the Care Coordination Model.

We will also use our advances in technology as noted above to improve coordination with other providers the youth may have on their care planning team. The use of secure email will help us to send privileged information back and forth with ease and not have to wait on "snail mail" or "lost faxes" to share and communicate documents. Telehealth video conferencing will also assist us in bringing team members to the table on a more regular basis especially in instances where distance, time, and access to one another is an issue.

Section 6.3 Populations Served and Community Engagement (3 Pages)

6.3 A: The Community Service Agency (CSA) at Child & Family Services (CFS) provides Intensive Care Coordination services to MassHealth enrolled youth, under the age of 21, with Serious Emotional Disturbances (SED) who meet the medical necessity criteria for this service. Our designated catchment area includes the cities and towns of New Bedford, Dartmouth, Fairhaven, and Acushnet. On occasion, we will provide services to youth and families that live in Wareham, Middleboro, Fall River, Taunton, Mattapoisett, Marion, and Freetown. While our focus is on providing services in our designated region, circumstances may warrant a need to operate outside of the service area. For example, when another CSA in the region is at capacity we will take referrals from other areas so that timely access to ICC services can be afforded to the family.

Intensive Care Coordinators promote and ensure the health and wellbeing of the individuals they serve through a coordinated systematic team based approach. CSA staff ensure that interventions and services are well-coordinated between team members, goals are prioritized, progress is consistently monitored, and gains are demonstrated through improvement in the Child & Adolescent Needs and Strengths (CANS) score. CSA staff use the ten principles of Wraparound to support the health and wellbeing of each youth and their families. The Wraparound principles guide the means by which staff support clients, beginning with the referral process in which staff actively engages with a family and "meets them where they are at".

Referrals are currently received in the form of fax, e-mail, telephone, and in person. CSA staff respond to each inquiry within 24 hours and offer a one-on-one appointment within three calendar days. Actively initiating and maintaining engagement is one of our core principles and each CSA staff member is trained on care coordination and the Wraparound model. CSA staff complete an initial safety plan and a Strengths, Needs and Culture Discovery assessment which helps guide the process and supports decision making and development of an individualized care plan.

Staff work diligently to create strong relationships with youth and families through listening and providing "voice and choice", which recognizes that successful outcomes and continued engagement are a direct result of family ownership of the ICP. Achievement of the care plan goals are increased when the Wraparound process reflects family members' priorities and perspectives. Addressing needs beyond behavioral health through the development of partnerships within the community assist in maintaining engagement with families. These partnerships enable CSA staff to connect families and/or youth to a variety of sustainable supports, such as recreational activities for the child, support groups for the parents/caregivers, faith communities, and community-based social events.

CSA staff are committed to improving communication amongst the providers and teaching parents how to effectively navigate the health system which leads to an increase in the continuity of care. Our proposal aims to improve the services described above by working towards fostering stronger integration with ACOs, PCPs, and Pediatric Practices, strengthening fidelity to Wraparound processes and improving timely access to care. Through specific improvements in technology, infrastructure and workforce development, our CSA program will

develop more efficient time savings practices, which in turn will reduce costs and improve care coordination skills. Technology improvements will better enable our program to promote the health and wellbeing of the individuals we serve.

6.3 B: The CSA at CFS maximizes the chances of accomplishing ICP goals through quality ICC services demonstrated by nurturing formal and informal community resources that support care plan teams. We currently have a thriving Systems of Care (SOC) in our area comprised of representation from the local school departments, DMH, DCF, DYS, the court system, the District Attorney's Office, the Bristol County Sheriff's Office, Parent Advocacy programs such as the Parent Information Network (PIN), multiple other CBHI program representatives from In-Home Therapy, Therapeutic Mentoring, and In-Home Behavioral Services, our local Mobile Crisis Intervention, nurse case managers from the Greater New Bedford Health Clinic, Early Intervention providers, daycare providers, the local Parks and Recreation Department, representative from the Managed Care Entities, the local Family Resource and Development Center, the local housing authority, Immigrants' Assistance Center, our local City Hall and Health Department, and various other mental health and substance related disorder providers in the area. We convene and cultivate the local Systems of Care Committee monthly.

The SOC committee serves as an advisory committee to the CSA and supports the following:

- Quality management processes that address opportunities to improve the delivery of the CSA services including reviewing systemic barriers, and identifying and fostering community resources and relationships to promote sustainability.
- Community resource monitoring and development, including identifying gaps in services, building capacity of resources and supports, and improving linkages with schools and other community based natural supports. These relationships help us to be more effective in assisting families to access different support and/or services offered.
- Issues or themes related to the delivery of ICC services including access and coordination barriers. SOC provides assistance in navigating access to address needs of youth and families served by the CSA Program.

Additionally, our CSA participates in a monthly meeting with the Department of Mental Health (DMH) and Department of Children and Families (DCF), as well as a bi-monthly interagency meeting with representatives from the Department of Elementary and Secondary Education (DESE), Department of Developmental Services (DDS), DMH, DCF, and the Department of Youth Services (DYS).

Both meetings offer an opportunity to present, examine and discuss high risk cases where we can tap into the expertise and collective knowledge of broader community agencies and brainstorm solutions for each case. The partnership meetings encourage robust discussion and problem solving around access to services and resources that the more extensive State agencies may be better equipped to provide. For example, our relationship with our DMH Systems Integration Specialist (SIS) has allowed eligible youth enrolled in the CSA program to access a DMH funded respite program and a DMH funded therapeutic afterschool program. This example demonstrates key Wraparound support opportunities that are crucial to the success of care plans and care coordination.

As demonstrated above we currently have strong and integrated care teams and community partners who contribute valuable expertise and services to the clients we serve. Our proposal is focused on building stronger and more integrated relationships with ACOs, PCPs, and Pediatricians located in our catchment area.

6.3 C: Our proposed investment projects focus on developing new partnerships with ACOs, PCPs, and Pediatric Offices while improving methods of effective efficient communication with current partners. These partnerships will align with our proposed and described projects in the areas of Workforce Development, Infrastructure and Technology as follows:

Workforce Development - Staff training in the areas of Integrated Care Management, Motivational Interviewing and Understanding Chronic Medical Needs will foster more integrated partnerships with both our current and proposed new partners. A deeper understanding of chronic medical needs will enable staff to identify challenges that impact behavioral health and offer care plan recommendations and referrals to appropriate partner organizations. Training in Integrated Care Management will help staff understand how changing from a passive health system that waits for the client/patient to be taken, into an active and engaging health system, is more inclusive and provides better health outcomes in the long term. This understanding is crucial in empowering staff to embrace and encourage the development of more meaningful relationships with ACOs, PCPs, Pediatricians and other community providers.

Operational Infrastructure and Technology - The integration of Care Coordination efforts for both current and planned partnerships will be improved with our proposed operational infrastructure and technology projects. Currently efforts to inform ACOs and PCPs of the services available under the CSA is hindered by an inability to invest the time in building trusting relationships directly with healthcare providers and an archaic system of information sharing and dialogue. The employment of an Integrated Care Liaison (ICL) whose principal focus will be to connect with ACO leadership, PCPs and Pediatric Offices to build enduring relationships, and educate and inform them of service options will achieve our development plan and DSRIP goals. Providers who understand services offered by the CSA will be better equipped to provide appropriate referrals which ultimately empowers each provider to approach their patients in a holistic manner serving the “whole” person instead of individual specific ailments.

Improving technology is a key strategy to cultivating low pressure and accessible relationships with all partners. Enhancements to our current electronic medical health record, Evolv, access to secure e-mail and telehealth services, connections to the Mass HIway, laptops, and translation software will provide smoother, easier access to care coordination and significantly enhance the collaborative, team and outcomes based principles of the Wraparound model. We attribute our growth and success to our significant and growing network of partners. The ability to work collaboratively, engage key stakeholders and expand partnerships is a central component to achieving positive and sustainable outcomes for our youth and families.

Section 6.4 Proposed Projects and Investment Plan (15 Pages)

6.4 A. Project Description #1 - <u>Workforce Development Project</u>

1. Name or title of the specific proposed project: Enhancing the Quality and Integration of Care Coordination by means of Workforce Development Training and Certification for Community Service Agency (CSA) staff

2. The specific goal, as defined in Section 3.4, advanced by the project and plans to address the goal through the proposed project:
The CSA of Child & Family Services' proposed Workforce Development Project will advance the following goals as defined in section 3.4: Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members; Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families; Improving timely access to ICC services for children eligible to receive ICC and their families; Improving integration among physical health, behavioral health, long-term services and supports and health-related social services; and to sustainably support safety net providers to ensure continued access to care for Medicaid and low-income, uninsured individuals.

Child & Family Services (CFS) recognizes the ongoing need to improve integrated care management and delivery of services in pursuit of the Delivery System Reform Incentive Program (DSRIP) goals. CFS's CSA Program Director has identified training opportunities that would best improve CSA staff knowledge. Training program selections were aligned with advancing program goals.

Intensive Care Coordination requires CSA staff to facilitate care planning that is driven by the needs of youth characterized as having Serious Emotional Disturbance(s) (SED). Creating a Wraparound integrated youth and family centered care plan involves collaboration and multifaceted partnerships across a variety of settings, including a youth's home, school, community and healthcare locations. Intensive Care Coordination requires highly qualified staff with specialized educational training. Maintaining highly qualified staff requires an investment in professional development where staff can learn about constantly evolving methodologies, strategies and healthcare regulations.

CFS has identified three areas where training would prove beneficial for staff in providing better care coordination and Wraparound support to clients. The three areas include Motivational Interviewing, Integrated Care Management and Understanding Chronic Medical Needs. Training programs/certifications have been identified and will be pursued by staff based upon roles and responsibilities. The descriptions of each type of training and their connections to program goals are as follows:

Motivational Interviewing - *Building One's Knowledge of Motivational Interviewing*: the course is offered at the UMASS Center for Integrative Primary Care and provides a clinical approach that helps people with mental health and substance use disorders and other chronic conditions, to make positive behavioral changes to support better health. Staff training in the field of Motivational Interviewing will improve fidelity of the Wraparound model based on improving

staff skills set in the area of assessment. Motivational interviewing techniques will better assist staff to engage with a client, help them identify their strengths and needs which will improve and support the Wraparound process leading to overall more effective and sustainable outcomes.

Integrated Care Management – The certificate program in Integrated Care Management will develop staff's general skills focused on engaging patients, promoting their motivation to improve their own health, and general medical and behavioral health skills to be able to connect them to appropriate services, address questions, teach healthy living and support patient-centered treatment plans. Staff trained in Integrated Care Management will better understand how care management plays a crucial role in the Patient-Centered Medical Home (PCMH). Staff will understand how changing from a passive health system that waits for the client/patient to be taken, into an active and engaging health system, is more inclusive and provides better health outcomes. This understanding is crucial in empowering staff to embrace and encourage building of strong relationships with ACOs, PCPs and other service providers. Expertise in both the care management tasks of the healthcare system and the mental health system is a necessary skill in a successful care coordination model. While staff know that outreach is required as part of the role as a Care Coordinator, the knowledge and understanding of why outreach and engagement is crucial to success will empower staff to take ownership of their role. Staff who enroll for the Integrated Care Management Certification will enhance their knowledge around medically complex needs and how they can be integrated into the behavioral health model.

Integrated Care Management is particularly important in situations where the engagement between the person and the health system is likely to fail, such as transitions of care, barriers to access, poor fit between the person's social skills and medical understanding and the level of either required to maintain health or to access care. Obtaining a Certification in Integrated Care Management will improve staff's understanding and facilitation of Wraparound support services.

Understanding Chronic Medical Needs – According to publication by The National Academies Press and funded by the National Institute of Health, mental health, substance-use problems and other illnesses rarely occur in isolation. Often, they accompany each other, along with general medical illnesses such as diabetes, and neurological illnesses. Since these conditions are intertwined, coordination of health care is essential to improved health outcomes. [1] The purpose of the CSA Wraparound model is to link families to supports and resources that best meet their individual needs. Research has demonstrated that individuals with co-existing health barriers do not receive the holistic care they need to overcome these barriers because "disconnected care delivery arrangements requires numerous patient interactions with different providers, organizations, and government agencies"[2] To address these issues we propose to train CSA staff on Chronic Medical Needs which will help staff understand conditions that impact behavioral health, thus enabling them to locate resources that best meet client's individual needs. Our expanding partnerships and proposed hiring of an Integrated Care Liaison, discussed later in the proposal, will further improve the coordination of care through an emphasis on effective communication and a clearer sense of shared goals and roles between

Community Service Agencies and Primary Care Providers.

[1] (Series, 2006); [2] (Series, 2006, p. 1)

3. The scope of the project, including duration of time during which the funds received under the Contract shall support the project, and the planned methods and activities that shall be performed to achieve the identified goal.

UMASS Medical online training programs are self-paced and begin in the spring and fall semesters. The bulk of training will take place during the preparatory period and the CSA Program Director will oversee all training related components including enrollment, support, completion and implementation. Training funds will be allocated throughout each budget period to deliver new skills to CSA staff and reinforce current learning and knowledge. The Motivational Interviewing course will be pursued in a team-based approach, where staff will come together during team meetings to watch online modules and then discuss and practice techniques demonstrated and new skills gained. Understanding Chronic Medical Needs training will be delivered throughout the first year.

We are actively developing more well-defined relationships with our local ACOs and intend to work in partnership with them to identify appropriate training on Chronic Medical Needs such as diabetes, cystic fibrosis, ADHD, food allergies and asthma. Working with ACOs to support and advise on necessary training will strengthen our efforts in building trusting and more collaborative relationships. Care providers are more likely to collaborate when they "perceive each other as having the knowledge necessary for good clinical care". [1] Multiple DSRIP goals naturally align with these strategies and we believe care integration through education will improve the fidelity of the wraparound model.

[1] (Series, 2006, p. 2)

4. Proposed deliverables that will result from the project.

Training in the three areas of Motivational Interviewing, Integrated Care Management and Understanding Chronic Medical Needs will have a direct and positive influence on all DSRIP program goals. Specific deliverables will include an upskilling of ICC staff, resulting in strengthening fidelity of Wraparound support services, and fostering strong integration with ACOs and PCPs. More specifically, there will be an increase in certified staff in Integrated Care Management, leading to an increase in collaboration with ACOs and PCPs through shared understanding of roles and responsibilities, and improved access to care for ICC engaged members.

5. Specific use of DSRIP funding the Bidder plans to make in order to execute the project and an explanation of how each investment will support the execution of the project goals.

DSRIP funding will be used to cover the cost of staff certifications and training in the areas of Motivational Interviewing, Integrated Care Management and Understanding Chronic Medical Needs. Investment in staff training and knowledge will support the execution of project goals of Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members; strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families; improving timely

access to ICC services for children eligible to receive ICC and their families; improving integration among physical health, behavioral health, long-term services and supports and health-related social services; and to sustainably support safety net providers to ensure continued access to care for Medicaid and low-income, uninsured individuals as described in depth in section 6.4 A-2.

6. Existing internal resources (e.g., funding, staff, business site, IT systems, hardware) the Bidder plans to use to implement the project.
Internal resources to be used for the project include staff salaries and IT equipment. Staff will be provided time each week to complete training course modules.

7. An explanation of how funds will be allocated across the Bidder's organization and CSA site(s).
Child & Family Services (CFS) has only one CSA site, therefore, all funds for training will be allocated to the single CSA site.

8. The internal evaluation, measurement or performance management strategies the Bidder will apply to the proposed project to demonstrate effectiveness, including plans to collect quantitative and/or qualitative data regarding program activities, outcome measurements the Bidder proposes to use, and the staff responsible for this task.

a. Measurement Strategy: staff will participate in a survey that will rate their confidence in their skills and abilities both before and after completion of the courses in :
   Integrated Care Management and Motivational Interviewing.
   Program director will design a survey with questions rated on a Likert Scale of 1-7 (1 being not at all confident- 4 Neutral- 7 Extremely Confident) in the following area: (sample questions)
   Integrated Care Management- please rate your comfort level with networking in the medical neighborhood?
   Motivation Interview Skills- please rate your ability to verbalize an understanding of the patient's point of view
   Before taking the course (score) vs. After taking the course (score)
b. Timeframe: We will have all trainings and surveys completed by the end of Budget Period 2
c. Goal: To increase staff competency and confidence on the topics of Integrated Care Management and Motivational Interviewing in order to improve collaboration with Primary Care Providers and improve our ability to capture needed info for assessments and Strength, Needs, and Culture Discoveries.
d. We will collect the data in survey form at the end of each training course
e. The CSAs administrative assistant and program director will compile data for scores.

6.4 A. Project Description #2 - <u>Operational Infrastructure Project</u>

1. Name or title of the specific proposed project. Integrated Care Liaison (ICL)

2. The specific goal, as defined in Section 3.4, advanced by the project and plans to address the goal through the proposed project.

The CSA of Child & Family Services' proposed Operational Infrastructure Project will advance the following goals, as defined in section 3.4: Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members; strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families; sustainably supporting Safety Net providers to ensure continued access to care for Medicaid and low-income, uninsured individuals; and improving integration among physical health, behavioral health, long-term services and supports and health-related social services.

Our plan(s) to address these goals will include the employment of an Integrated Care Liaison who will focus on marketing and networking strategies.

The employment of a full time Integrated Care Liaison (ICL) will serve a dual role. The success of care plans requires a commitment from all stakeholders including the family, partners and collaterals. The current challenge is engaging and sustaining the attention and commitment of the client's Primary Care Physician (PCP). PCPs often see patients back to back throughout the day and rarely have time for additional meetings with a client's Wraparound Care Coordinator. The ICL's primary focus will be on building relationships with PCPs and bridging the information gap that currently exists between them and the ICC staff. The Integrated Care Liaison would be formally trained in all ICC services and serve in a management role within the program. We anticipate an increase in PCP referrals as a result of focused outreach efforts at PCP and Pediatric offices. Additional referrals will lead to an increase in revenue and provide sustainable resources for the added position.

3. The scope of the project, including duration of time during which the funds received under the Contract shall support the project, and the planned methods and activities that shall be performed to achieve the identified goal.

The CSA Program Director at Child & Family Services will function as the Project Manager for Infrastructure projects and will be responsible for hiring and providing training to the Integrated Care Liaison.

To meet our goals related to improved integrated care, as well as sustainable support for safety net providers and stronger relationships with PCPs, it will be crucial to identify, hire and fully train the appropriate candidate for the new position. We have provided the job description for the new position as an attachment which details the required skills and qualifications.

4. Proposed deliverables that will result from the project.

Deliverables will include the creation of a new Integrated Care Liaison position, new marketing and outreach materials, and a kick-off outreach event intended to bring together the ACOs, PCPs and pediatricians who will partner with the CSA for a networking opportunity to meet and discuss how to improve communication and partnerships in support of clients and patients.

5. Specific use of DSRIP funding the Bidder plans to make in order to execute the project and an explanation of how each investment will support the execution of the project goals.

Funding will be used to employ the Integrated Care Liaison. The ICL will be responsible for engaging and sustaining relationships with PCPs and Pediatric Offices, and will work directly with the Program Director to create an outreach strategy intended to increase ICC referrals and create deeper, more effective collaborative relationships with PCPs and pediatricians.

Additionally, funding will be used to support marketing and event coordination costs for the kick-off event designed to engage, connect and begin to build relationships with ACOs and PCPs. One of our core responsibilities is to foster strong integration between these entities which will in turn strengthen fidelity to the Wraparound processes, improve access to ICC services and advance our quality improvement plan goals.

6. Existing internal resources (e.g., funding, staff, business site, IT systems, hardware) the Bidder plans to use to implement the project.
Existing internal resources include our HR department for recruitment purposes and CSA Program Director, both of whom will serve as project leads for the proposed infrastructure projects.

7. An explanation of how funds will be allocated across the Bidder's organization, and CSA site(s).
Child & Family Services (CFS) has only one CSA site, therefore, all funds for training will be allocated to the single CSA site.

8. The internal evaluation, measurement or performance management strategies the Bidder will apply to the proposed project to demonstrate effectiveness, including plans to collect quantitative and/or qualitative data regarding program activities, outcome measurements the Bidder proposes to use, and the staff responsible for this task.

a. Measurement Strategy: We will see an increase in overall referrals made by PCPs by at least 40%.
b. Timeframe: We anticipate this increase by December 2020
c. Goal: To increase our current enrollment of 115 youth to 130 youth
d. We will collect the data by utilizing the Statewide CSA Monthly Statistics Reports (which captures all referral data and enrollment information on a monthly/yearly basis)
e. The CSA Admin Assistant, the Program Director, and Senior Care Coordinators

6.4 A. Project Description #3 - <u>Technology Project</u>

1. Name or title of the specific proposed project.
Technological Improvements and Innovative Investments

2. The specific goal, as defined in Section 3.4, advanced by the project and plans to address the goal through the proposed project.
The CSA's Technology Project will address the following goals, as defined in section 3.4: Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members; strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families; and Improving timely access to ICC services for children eligible to receive ICC and their families. Additionally,

the technological investments and improvements align with the DSRIP and CSA Development Plan goals of Implementing payment and delivery system reforms that promote member-driven, integrated coordinated care, and hold providers accountable for the quality and total cost of care; improving integration among physical health, behavioral health, long-term services and supports and health-related social services; sustainably support Safety Net providers to ensure continued access to care for Medicaid and low-income, uninsured individuals; ensuring that all pertinent information is available for MCE record review in order to meet medical record standards; and improving our team member attendance scores (such as youth attendance, key stakeholders, attendance, PCP participation, and natural supports) related to the data from the TOMS in the WPPA report for 2016.

Intensive Care Coordinators (ICC) currently rely primarily on desktop computers for all documentation needs and a limited number of laptops and e-signature pads for completing intake services in the field. The purchase of 2-in-1 laptops and Skype for business accounts for all CSA staff will address the stated goals in the following ways:

2-in-1 Laptops - First, the purchase of 2-in-1 laptops for all CSA staff will strengthen fidelity to Wraparound processes by ensuring all staff and ICC engaged members have instant access to all care coordination documents during care plan meetings. Additionally, the majority of our families do not own a computer, so to access technology, our families are asked to come to the agency or other settings such as a library or career center. The ability to bring technology to our youth and their families will improve access to services and streamline the care coordination process. For example, a Family Partner staff may be working on a storyboard with a family that creates a virtual vision of Strengths, Needs and Cultural Discovery. The ability to work on this project in a comfortable and safe environment for the family is fundamental to strengthening fidelity.

Finally, laptops will allow our staff to complete the necessary paperwork while in the field. This is an efficient approach that will decrease costs, improve collaborative partnerships and free up additional staff hours. Staff could then use this time to attend trainings, provide additional supports to Safety Net providers through relationship building, and document and track down pertinent information to meet medical record standards, which aligns with our Development Plan goals. If a document is requested by the family and the Care Coordinator does not have the specific document, valuable time and resources are lost. Mobile technology will improve access to ICC services through the instant availability of important documents.

Telehealth Capabilities - In addition to the purchase of laptops, CFS proposes to purchase telehealth capabilities through either Skype for Business or Omni-join. Telehealth capabilities will facilitate the process of fostering strong integration with our ACOs, PCPs and pediatricians, allowing other providers to participate in the care planning process and meetings if they cannot be there in person, due either to distance or an inability to break away from work. Many of our PCPs see patients back to back all day long, making it virtually impossible for them to attend an hour and a half care planning meeting. Telehealth capabilities will better aid in bringing members of the Primary Care team to the table during essential meetings with our youth and their families.

Furthermore, Telehealth capabilities will allow for remote access of the youth's natural supports, which, in turn will strengthen fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families. Often our youth's natural supports are not physically able to be in the location of the care planning meetings, as they may live in another state or not have reliable access to transportation. Natural supports are crucial to the sustainability of active participation and follow through in care coordination planning. Natural supports provide a sense of safety and security to the youth and their families in addition to a team primarily comprised of professionals. Telehealth capabilities will also allow for remote access to other providers on the team who also may not be able to attend in person such as DCF workers, school personnel, psychiatrists, and therapists.

Translation Software - In pursuit of program goals, we propose to purchase translation software that will improve timely access to ICC services and strengthen fidelity to Wraparound processes. Currently, CSA staff working with non-English speaking families create and revise all documents such as the Individual Care Plan, Safety plans, Transition Indicators and Assessments in English. Following the completion of the English version, bilingual staff will then translate the document into the family's native language in order to meet cultural and linguistic competencies.

Translation software would relieve the CSA's bilingual staff of the burden of hand-written translation, freeing up additional time and essentially allowing for an increase in the staff's caseload. Currently, bilingual staff have a reduced caseload due to the extra time required when working with non-English speaking and bilingual families. An increase in Care Coordinator's caseload would improve timely access to ICC services.

Secure E-mail and Connections to the Mass HIway/EHR Enhancements - We propose to address the goals of integration among physical health, behavioral health, long-term services and supports, and health-related social services; sustainably supporting Safety Net providers in order to ensure continued access to care for Medicaid and low-income, uninsured individuals; and fostering strong integration with ACOs and primary care providers for ICC-Engaged Members.

To address these goals, we propose to add 13 additional connections to the Mass HIway portal and purchase secure/encrypted email software for all CSA staff. Connection to the Mass HIway offers a secure connection and the portal offers a way to securely and seamlessly transmit vital data electronically. There are currently 3 ACOs in our designated service area who are using the Mass HIway – Southcoast Hospitals Group, Beth Israel Deaconess Hospital, and the Greater New Bedford Health Center; however not all partners are connected to the HIway. Secure email services will provide CSA staff with a more efficient and effective means of transmitting client-sensitive information, thus allowing staff to send and receive privileged information to Primary Care Physicians, collaterals and other providers on the team who may not be on the Mass HIway, but who we are expected to communicate and collaborate with as part of the care coordination team.

Due to HIPAA regulations, our CSA staff cannot upload any documents with identifying information into our current messaging system. Secure e-mail would allow staff to upload vital

documents that can be shared with each member of the care planning team. Supporting Safety Net providers and strengthening integration among physical health, behavioral health, long-term services and supports and health-related social services would increase with the ability to send secure emails to all partners. Additionally, secure email services would cut agency costs. For example, currently Managed Care Entities (MCEs) require that documentation is delivered to the families and partners within seven days of the care planning meeting. Currently, staff spend an inordinate amount of time making copies, addressing, stamping and mailing documents. Any changes to a care plan require that the updated version is current and shared with all partners. On average, CFS' CSA has 104 ICC engaged members each month. The best practice is one care plan meeting a month. If all staff send out one new care plan a month to four partners, the total number of pages being copied and mailed would amount to more than 300 pages. The time spent on these tasks is more challenging to calculate, however, we can presume that the ability to electronically transmit the new paperwork would be a more efficient and effective practice.
Additional connections to the Mass HIway and secure email services will support stronger integration with ACOs and primary care providers for ICC-Engaged Members, improve integration among physical health, behavioral health, long-term services and supports and health-related social services; and support Safety Net providers to ensure continued access to care for Medicaid and low-income, uninsured individuals.

Enhancements to our EHR system are intended to capture new data required for Quality Measures reporting, build out new reports that will reveal quantitative metrics intended to drive care planning conversations amongst the team, and support the Wraparound process. Enhancements will include, but are not limited to, creating new forms and fields in the EHR to capture the dental appointments, PCP wellness visits, and After Care Outpatient Appointments.

3. The scope of the project, including duration of time during which the funds received under the Contract shall support the project, and the planned methods and activities that shall be performed to achieve the identified goal.
The IT Director at Child & Family Services will function as the Project Manager for IT-related projects. Our Director of Technology has been consistently involved in the RFR planning process and will be responsible for all technology product purchases and associated tasks, training and implementation, and Technology Project goals.

To meet our Technology Project goals, training on appropriate Telehealth practices, translation software, using secure email and accessing the Mass HIway, along with ensuring laptops are equipped with the proper software and operating systems, will be crucial to the success of the project. The purchasing and training for all technology investments will take place during the preparatory budget period.

4. Proposed deliverables that will result from the project.
Proposed deliverables include the purchase of 25 laptops, Telehealth product, Translation Software, Secure Email Licenses and 13 additional connections to the Mass HIway.

5. Specific use of DSRIP funding the Bidder plans to make in order to execute the project and an explanation of how each investment will support the execution of the project goals.
Funding will be used to purchase 25 two-in-one laptops, Telehealth and Secure Email services, translation software, and 13 additional connections to the Mass HIway for all CSA staff. The purchase of mobile technology and telehealth services will enable staff to strengthen fidelity to Wraparound support services through improved participation with natural supports and other collaterals. This technology, along with additional connections to the Mass HIway and secure email services will support stronger collaborative partnerships with ACOs, PCPs and Pediatric Offices and improve access to care, as CSA staff will more efficiently be able to record and access information and data necessary to successful care planning and integrated care coordination. Training is required to ensure that all staff understand the value of the translation software, have the technical skills and an opportunity to use the product.

Additionally, funds will be used to purchase two large screen televisions that will be placed in the two main conference rooms. The televisions will be used for Telehealth conferencing sessions with the care planning team, natural supports, community and primary care partners.

6. Existing internal resources (e.g., funding, staff, business site, IT systems, hardware) the Bidder plans to use to implement the project.
Existing internal resources include the use of our IT Director who will serve as the project lead for the technology component.

7. An explanation of how funds will be allocated across the Bidder's organization, and CSA site(s).
Child & Family Services (CFS) has only one CSA site, therefore, all funds for training will be allocated to the single CSA site.

8. The internal evaluation, measurement or performance management strategies the Bidder will apply to the proposed project to demonstrate effectiveness, including plans to collect quantitative and/or qualitative data regarding program activities, outcome measurements the Bidder proposes to use, and the staff responsible for this task.

a. Measurement Strategy: We would like to see an increase in our TOMS 2.0 and WFI-EZ scores in the categories of Natural Supports and Full Meeting Attendance by utilizing Telehealth Capabilities to virtually bring people into the meetings.
b. Timeframe: We anticipate a significant increase and the results by the end of Budget Period 3 (Dec 2020)
c. Goal: We would like to see an increase in our overall average scores from current average of 66% to 75% for Meeting Attendance and 68.5% to 80% for Natural Supports
d. We will collect the data from the results of the WPPA (Wraparound Provider Practice Analysis) and fidelity assessment scores.
e. The Program Director and Senior Care Coordinators will collect and submit the data.

6.4 B. Project Team description

B1. Child & Family Services CSA Organizational Chart (See Attachment).

B2. Child & Family Services CSA List of Current Staff that will be involved in the projects, including their Job Descriptions and qualifications for the projects.

Current Staff involved in the projects are as follows:

a) Site Director, Jeanne Bissonnette holds a Master's degree in Social Work and is a Licensed Independent Clinical Social Worker. Jean has been with Child & Family Services since 1998. Jean is currently the Site Director for our Acushnet Avenue site and is responsible for seven outreach programs which includes three CBHI programs.

b) IT Department Manager, Mirian Sousa holds a Bachelor's Degree in Business Administration and Computer Technology and coursework towards a Master's Degree in Computer Engineering. Mirian has been with Child & Family Services since October 2015. Mirian is responsible for directing, planning and organizing all activities of the IT department to ensure effective and secure operation of all automated data processing systems.

c) CSA Program Director, Erin McAlonan holds a Master's degree in Expressive Arts Therapy/Counseling. Erin has been a part of the CFS since 2005 and currently serves as the Program Director for the CSA.

d) Finance Manager, Paula Medeiros has a Bachelor's Degree in Accounting and has been with Child and Family Services for 14 years. Paula is currently the Finance Manager for the entire organization and is responsible for maintaining records and systems of accounts for recording the Agency's financial transactions, preparing internal financial statements, preparing monthly and annual financial reports for the Chief Fiscal Officer, designing and maintaining a system on internal checks, and controls for the proper safeguarding of the assets and accurate recording and reporting of accounting transactions.

All CSA staff, including Intensive Care Coordinators and Family Support Partners will participate in the proposed trainings.

Job Descriptions and Qualifications (Credentialing Log) for the Projects (See Attachments).

B3. Any staff the Bidder proposes to hire or engage to be involved in the project(s), including their proposed job descriptions and qualifications for the project(s).

We propose to hire a full time Integrated Care Liaison (ICL). We have created the job description that lists the required qualifications and skills **(See Attachment)**

B4. The roles and responsibilities of each staff of the Bidder's Project Team and how the Bidder will ensure efforts are coordinated among staff and not duplicated.

Each member of the project team has designated roles and responsibilities to ensure that efforts are not duplicated. Each team member has been involved with the development of each project and have worked collaboratively throughout the process. More specifically:

Jean Bissonnette, the Site Director is responsible for supervising all aspects of the CSA Program including fiscal oversight. Jean will be responsible for working with the Program Director, IT Director and Finance Manager to ensure that budgets are allocated and managed appropriately and accurately.

Mirian Sousa, The IT Department Manager will work with senior management and the CSA Program Director to ensure that the implementation of technology purchases and training needs proposed by the RFR is provided in a timely, secure and easy accessible manner.

Erin McAlonan, The CSA Program Director will serve as the lead project manager for the implementation of training and hiring of the Integrated Care Liaison. Erin will work collaboratively with the Site Director and IT Department Manager to ensure technology purchases and implementation proposed by the RFR are adhere to the project plan, proposed timeline and budgetary expenditures.

Paula Medeiros, The Finance Manager will work closely with the Site and Program Directors and the Chief Financial Officer to ensure that the budget is allocated and managed appropriately and accurately.

B5. A description of how the Bidder proposes to manage the project(s).
The projects will be managed by each designated team member as described above based upon the needs and content or technical requirements of each project. The overall project lead will be the Program Director, Erin McAlonan with oversight and support by the Site Director. Erin will be responsible for ensuring that each project is carried out according to the DSRIP participation plan agreement. Erin will partner with the Finance Manager on budget management matters, with the IT Department Manager with all technology investments and project implementation, and with all CSA staff to ensure a smooth implementation process throughout the execution of each project.

6.4 C. Implementation Plan and Timeline

Prep Budget Period (January 2018 - May 2018)

- Hire and provide training for the Integrated Care Liaison
- Continued outreach to ACOs, PCPs and pediatricians
- Research appropriate technology products and purchases.
- Purchase touchscreen laptops, translation software, secure email and telehealth licenses, television monitors, 13 additional accounts for Mass HIway
- Complete upgrades/and quality enhancements to Wi-Fi and EHR to begin capturing required quality metrics
- Provide staff training on new processes for capturing required quality metrics
- Research, development and purchasing of marketing materials for promotions at ACOs, PCPs and Pediatric offices and for the Kick-off Event
- Registration for Integrated Care Management and Motivational Interviewing certification training
- Research trainings for Understanding Chronic Medical Needs i.e.: Diabetes, Asthma, Obesity and Food Allergies
- Prepare semi-annual progress report
- Begin developing policies and procedures for all technology requirements and train staff
- Design and begin implementing staff training for technology enhancements, new technology purchases specifically on the use of confidential and secure information sharing technologies

Budget Period 1 (June 2018 - August 2018)

- Begin planning and preparing for the Kick-off Event
- Coordinate amongst other CSA providers for opportunities to collaborate on the Kick- off event
- Ongoing research on training opportunities and enrolling staff in training/certification programs as appropriate
- Ongoing training on the use of confidential and secure information sharing technologies

Budget Period 1 (September 2018 - October 2018)

- Host the Kick-off Event
- Ongoing research on training opportunities and enrolling staff in training/certification programs as appropriate
- Ongoing training on the use of confidential and secure information sharing technologies

Budget Period 1 (October 2018 - December 2018)

- Prepare and submit EOHHS annual report
- Ongoing research on training opportunities and enrolling staff in training/certification programs as appropriate

Budget Period 2 First Quarter (January 2019 - March 2019)

- Ongoing research on training opportunities and enrolling staff in training/certification programs as appropriate
- Refresher training on the use of confidential and secure information sharing technologies and any updates/upgrades

Budget Period 2 Second Quarter (April 2019 - June 2019)

- Prepare and submit semi-annual progress report
- Ongoing research on training opportunities and enrolling staff in training/certification programs as appropriate
- Refresher Workforce Development Trainings

Budget Period 2 Third Quarter (July 2019 - September 2019)

- Ongoing research on training opportunities and enrolling staff in training/certification programs as appropriate
- Refresher training on the use of confidential and secure information sharing technologies and any updates/upgrades

Budget Period 2 Fourth Quarter (October 2019 - December 2019)

- Prepare and submit EOHHS annual report
- Ongoing research on training opportunities and enrolling staff in training/certification programs as appropriate

Budget Period 3 First Quarter (January 2020 - March 2020)

- Refresher Workforce Development Trainings
- Refresher training on the use of confidential and secure information sharing technologies and any updates/upgrades

Budget Period 3 Second Quarter (April 2020 - June 2020)

- Prepare and submit semi-annual progress report

Budget Period 3 Third Quarter (July 2020 - September 2020)

- Refresher Workforce Development Trainings
- Refresher training on the use of confidential and secure information sharing technologies and any updates/upgrades

Budget Period 3 Fourth Quarter (October 2020 - December 2020)

- Prepare and submit EOHHS annual report

Budget Period 4 First Quarter (January 2021 - March 2021)

- Refresher Workforce Development Trainings
- Refresher training on the use of confidential and secure information sharing technologies and any updates/upgrades

Budget Period 4 Second Quarter (April 2021 - June 2021)

- Prepare and submit semi-annual progress report

Budget Period 4 Third Quarter (July 2021 - September 2021)

- Refresher Workforce Development Trainings
- Refresher training on the use of confidential and secure information sharing technologies and any updates/upgrades

Budget Period 4 Fourth Quarter (October 2021 - December 2021)

- Prepare and submit EOHHS annual report

Budget Period 5 First Quarter (January 2022 - March 2022)

- Refresher Workforce Development Trainings
- Refresher training on the use of confidential and secure information sharing technologies and any updates/upgrades

Budget Period 5 Second Quarter (April 2022 - June 2022)

- Prepare and submit semi-annual progress report

Budget Period 5 Third Quarter (July 2022 - September 2022)

- Refresher Workforce Development Trainings
- Refresher training on the use of confidential and secure information sharing technologies and any updates/upgrades

Budget Period 5 Fourth Quarter (October 2022 - December 2022)

- Prepare and submit EOHHS annual report

6.4 D. Budget Report and Budget Narrative (See Attachments B & C).

6.4 E. Sustainability

Developing sustainable projects once the grant funding has ended was a priority when selecting and determining which capacity and infrastructure projects would be proposed in the RFR. The preparatory budget will be used to purchase the necessary technology.

Workforce Development

Workforce development training in the areas of Integrated Care Management and Motivational Interviewing will be completed during the budget preparatory period. Additional training around will be researched, identified and implemented over the first budget period using

budget period one funds. We anticipate training in these areas will increase access to ICC services, strengthen fidelity to Wraparound processes and build stronger relationships with ACOs, MCOs and PCPs, leading to an increase in referrals and ultimately an increase in program revenue. An increase in program revenue will allow the CSA program to continue investing in additional training/professional development by the end of the grant period.

Additionally, a Train-the-Trainer model will be practiced for sustainability and new hire training objectives. We will utilize Supervisors and Peer Trainers during orientation of new staff to ensure that all staff have the education and knowledge required to meet the needs of our clients. Ongoing trainings on topics as refresher courses will be arranged and presented during staff and individual supervision meetings.

Operational Infrastructure

Employment of the new full time Integrated Care Liaison (ICL) will take place during the budgetary period. The principal responsibility of the ICL will be managing and improving the referral process in coordination with ACOs, MCOs, PCPs and Pediatric Practices. In our experience, when the CSA program begins to receive additional referrals, Intensive Care Coordinator caseloads will grow, thus generating extra revenue to support and sustain additional staff positions. Therefore, as the program continues to grow each year with a steady uptick in the number of referrals received, the need for DSRIP funding will be reduced and the ICL position will be absorbed into the CSA program expenses through a growth in revenue created by the increase in referrals.

Technology

Initial technology purchases will be completed during the preparatory budget period which will be comprised of laptops, secure e-mail and telehealth services, additional Mass HIway connections, translation software and television monitors. There will be minimal ongoing costs that decrease over the course of the grant period as the CSA program begins to absorb the annual upkeep and other costs associated with the proposed technology purposes.

Procurement of these technology investments will enable the CSA program to cut costs through time and cost saving advancements in technology as described in more detail in section 6.4. The proposed technology investments will create a more cost effective and efficient work flow, leading to direct financial savings. Financial savings will be reinvested into the CSA program which is intended to support ongoing upgrades, monthly/yearly subscription costs, repairs and expected expenditures now required by the purchase and investment in new technology.

Section 6.5 Coordination with ACOs, MCOs, and Primary Care Providers (3 pages)

6.5 A. Bidirectional communication between the Bidder and pediatric practices.
Improving bidirectional communication between our CSA program staff and pediatric practices will be addressed and pursued through our proposed projects. We feel the most significant contribution to improving bidirectional communication will be the role of the Integrated Care Liaison (ICL) followed closely by upgrades in technology and an investment in new technology products.

The role of the CSA staff is to facilitate care planning and coordination for youth and their families. The ability to effectively communicate and easily share information with all partners is essential to meet care plan outcomes. The current challenge facing our staff regarding bidirectional communication efforts between ACOs, PCPs and Pediatric Providers is the lack of education and understanding that these entities currently possess about CSA services. The role of the ICL will be to provide outreach and education to all medical sites within our catchment area beginning with ACOs, PCPs and Pediatric Offices. Through educating and fostering relationships built on mutual trust and understanding, we anticipate a greater responsiveness and willingness to participate in care coordination efforts. While new protocols will require primary care practice designees to approve care plans, this will not necessarily support care coordination efforts unless the physician is an active and engaged partner. Another important goal of the ICL will be to better understand the needs of the physicians' offices, and based on these needs, implement strategies that will improve the integration of behavioral and physical health care.

Improvements in technology including the use of secure e-mail services will increase the ease of access to care plan documents that will contribute to improving bidirectional communication. Physicians who can access care plan documents and communicate with ICC staff via e-mail instead of paper documents is a more conducive, time saving method of communication for both the physicians and CSA staff.

6.5 B. Referral management protocols for follow-up and informational sharing.
We currently rely on our senior management staff to successfully triage and manage the referral process, as they are best qualified to discuss the appropriateness of a referral. For example, if a potential client calls the CSA office to discuss program options and their needs, our senior staff are well trained to evaluate the needs, ask the "right" questions and explain what services the CSA program can offer and provide next steps.

We are committed to providing appropriate and responsible referrals as oftentimes families who call may not necessarily be a "good" fit for the CSA program. If a family is not the "right" fit for the CSA program, we refrain from simply explaining that the program is not for them, instead we provide contacts and resources for the services they can take advantage of throughout the community. For example, we have had instances where an individual, directed by their PCP, has called the CSA program to inquire about mental health services. The CSA program was not the "right" fit for their needs but we were able to provide them with the appropriate contact for mental health service supports. Educating the community, especially

pediatric offices, will help physicians better understand resources and tools that the CSA can offer, ultimately cutting down on inappropriate referrals.

In addition to education, the enhancement of current technology and addition of new technology geared towards creating a leaner and resourceful referral processes, will improve communication and timeliness of access to care. The ability to send secure emails in lieu of paper or phone calls to physicians, who are challenging to reach by phone, will improve information sharing between all partners.

Through these targeted improvements, we will better facilitate youth and their families in obtaining services in a timely manner, and ensure that all care plan team members obtain the information they need when they need it. More efficient and time saving practices are important steps toward improving client outcomes and creating a less stressful work environment.

6.5 C. Team-based treatment planning in collaboration with pediatric practices.
Two of our core principles in care coordination and Wraparound principles include collaboration and team based approaches. While each care coordination team makes every effort to engage with PCPs and pediatricians, we are forced to compete with the limited time physicians generally have on any given day. We intend to improve team based treatment planning with pediatric practices through targeted outreach of the ICL staff member and Telehealth services aimed at increasing participation amongst pediatricians, PCPs and other team members whose time is either limited by the scope of their work or who cannot attend care planning meetings for one reason or another. We believe that as pediatricians learn more about the services we offer and can more easily access us through secure email services, Mass HIway connections and telehealth services, the more success we will have creating an appropriate care plan, evaluating and determining goals and initiating effective strategies to achieve DSRIP and development plan goals.

6.5 D. Timely access to ICC services.
Currently, the CSA program meets the timely access to ICC service standards. We receive, process referrals, and offer initial intakes within the targeted timeframe.

6.5 E. Connections to social services.
Coordinated care across multiple life domains is the primary service that CSA staff offer youth and their families. The initial intake and assessments are intended to identify the individualized needs of the youth and their family members. As demonstrated and described in more depth in section 6.3B, the SOC partnership provides access to resources from numerous organizations that provide distinct services to youth and their families. SOC partner organizations include community service nonprofits, youth and law enforcement agencies, school departments, mental and behavioral health facilities, immigration, and city services. These collaborative partnerships provide the tools and information for Wraparound support services that CSA staff use to provide appropriate care planning.

An example of how we utilize connections to social service agencies can be noted in the case of an eighteen year old youth who was displaced from his home and was struggling to find housing resources. The Care Plan team (ICC, Peer Mentor, school representatives) was brought

together to help the youth identify local homeless shelters and programs that assist independent living and housing needs. The youth was referred to the Department of Transitional Assistance, and Catholic Social Services. Additionally, the access line for local homeless shelters was brought in as a resource. Through our social services connections, the team was able to connect the youth to these social supports and services, ultimately finding him safe and affordable housing for the night.

We consistently work towards improving connection to social services and expect our proposed projects to further expand and improve our social service connections through improved and new technology, workforce development training and engagement of the Integrated Care Liaison.

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Section 6.2: Executive Summary

A. Bidder's current performance on its Development Plan

The current Community Healthlink CSA Development Plans focus on: (1) increased quality of Safety Planning and Comprehensive Assessments; (2) improved Outcome Based Practice; and (3) improved access to ICC services - especially for Spanish speaking families. The CSAs have made good progress on these development goals. CSA leadership has implemented a new chart review tool to help track the quality of safety plans and assessments. A new Outcome Tool has been developed and is currently being piloted across the three CSAs. We will have our first set of data from this pilot in July 2017.

The access issue has been more of a challenge. Across CHL and LUK's three CSAs, we currently have 5 ICC and 5 Family Partner opening. In our experience, access to ICC services is most dependent on our ability to hire enough staff to meet the demand. Over the past seven years, when we are able to hire enough staff, we offered services within the required timeline, with a first appointment within three days of the family consenting to the program. However, recruitment is an ongoing challenge, especially for Spanish speaking ICC and Family Partners.

B. Bidder's strengths and needs

Community Healthlink utilizes the LEAN approach to Quality Improvement. We are in our second year of implementing LEAN Quality tools and processes across all agency programs. LEAN emphasizes staff empowerment and inclusion, and an approach which seeks to continually examine and improve systems and processes to improve the quality of care given to our clients. The opportunity to receive increased funding at this time to improve quality within the CSA programs fits seamlessly into our ongoing LEAN work.

CHL's CSA programs are overseen by Anthony Irsfeld, Ph.D., a longtime advocate, trainer, and coach of the wraparound process and the core values of CBHI. The leaders within each CSA are skilled practitioners of CBHI Wraparound; each has an average over 5 years of CSA experience. The CHL CSAs also have the added advantage of a sub-contract relationship with LUK, Inc. which gives families choices as to where to receive their CSA services. This has helped us provide greater access to ICC over the years. Both Community Healthlink and LUK, Inc. have long standing, collaborative relationships with the major child serving systems (i.e. schools, DCF, DMH, Juvenile Probation, Health Centers, PCPs) within our communities.

Our most challenging needs are in the areas of recruitment, training, Electronic Health Record and mobile technology. Recruitment and retention is a constant challenge. Our CSAs compete with hospitals, schools and the State which offer higher salaries and benefits. Because we often hire new graduates or individuals who are less experienced, we need an effective, streamlined orientation and pre-service training program. Also challenging is our current medical record which does not allow for easy monitoring of key aspects of quality and is half electronic and half paper. Finally, our staff need access to the Internet in the field to assist families, to access video interpreting and to complete notes and Care Plans while in the community.

C. Bidder's plans for improving timely access to ICC services

Improving timely access to ICC services requires us to have a full staff of ICC and Family Partners and to have the use of video translation services when needed. With this funding **(Project 4)** we will develop additional recruiting materials, increase our internet visibility and conduct more frequent and targeted recruiting events within our community. In particular, we

plan to partner with local organizations that serve the Spanish speaking community to help recruit Spanish speaking staff to the CSA.

We also are requesting funds to increase staff access to mobile devices and to the Internet. In doing so, staff will have access in family's homes and in the community to our Video Interpreter Service which we believe will be more effective than our current telephonic service in engaging families who do not speak English as their primary language in our CSA program.

D. Bidder's plans for improving care coordination, care planning, and care management for ICC-Engaged Members

Our plan for improvement in care coordination, care planning, and care management will focus on four areas: Project 1: A new Electronic Health Record; Project 2: Training; Project 3: Mobile technology for staff to use in the field, and Project 5: Video-conferencing equipment.

Project 1: CHL's current electronic health record is over 15 years old and needs replacement. CHL has selected a new ERH (Qualifacts – CareLogic) which we will be implementing in 2018 . The current CSA record is partially on paper and partially electronic. Tracking whether employees are behind or current with their documentation, and review of the quality of those documents is currently time consuming and cumbersome. The implementation of a new Electronic Health Record will greatly assist with the monitoring of individual staff as well as program performance. With the new EHR, supervisors will receive alerts notifying them about staff who are struggling with quality documentation. Managers will be able to develop and run reports that track program quality goals (such as percentage of youth making progress, which domains families are having the most success with, etc.). The record has tasking and communication features which will improve coordination. The EHR meets Meaningful Use and connects to the Mass HIway The increased efficiency the EHR will free up managers to spend more time coaching and improving staff performance. We propose to use DSRIP funding toward the development of the CareLogic EHR for the CSA work flow and required paperwork.

Project 2: We propose to use DSRIP funding to augment training for staff around working with special populations as well as increasing our effectiveness partnering with medical professionals, especially pediatric primary care. Funds will be used to purchase training materials as well as procure outside trainers to work with CSA managers and staff.

Project 3: CHL/LUK plan proposes to use a portion of the DSRIP funding to increase access to mobile devices for staff to use in the community with families. Staff report that the ability to access the Internet "in the moment" would increase their efficiency with making referrals and accessing information about community resources. For example, a Family Partner with a tablet could assist a family in their home in the moment to research housing options or camperships for their youth—rather than return to the office, do the research, and report back to the family. In addition, the availability of tablets will allow staff to use video translation services when needed, rather than telephonic interpretive services which we believe will enhance the quality of services provided. The new web based EHR is also available on the tablet and staff can complete notes or update Care Plans in the home with the families collaboratively.

Project 5: We propose to purchase some equipment that can be used to assist us in video conferencing and training. Each of our 4 sites would have equipment so that trainings and

meetings could be held using the agency's subscription to Join-Me. This decreases the time staff travels to meetings between sites, thus increasing time available for families.

E. Bidder's plans to improve performance on quality scores and Development Plan goals
The initiatives listed above will each impact the CHL Development Plan goals and quality scores. The CHL CSA Development Plans currently focus on issues of timely access and quality of key processes (safety planning and assessment). Regarding access, we know that our ability to successfully recruit and train CSA staff is the key element to having sufficient capacity to meet the demand. We plan to use funding to help develop improved recruitment materials, and strengthen our community outreach recruitment efforts. In addition, the use of mobile devices and video interpretive services will increase the quality of the experience for families. We believe that use of a more functional EHR will assist managers and supervisors to more easily and efficiently monitor staff performance. They will be able to intervene with extra support, training, and coaching more quickly and it will allow for more efficient and frequent monitoring of program quality goals. Video conferencing will increase the efficiency of internal communication and allow for more frequent and regular meetings of supervisors and managers across sites which will assist with ongoing quality improvement.

F. Bidder's plans for improving coordination with pediatric primary care and other physical and behavioral health care providers across the care continuum for youth
The CHL Worcester CSA is currently involved in two pilot projects which are helping to improve coordination with pediatric primary care, and increase attention paid to physical health and wellness. One pilot involves the inclusion of a part time nurse-educator on staff at the CSA to assist with increasing staff knowledge and confidence in addressing physical wellness issues with families and as a result has increased our coordination with PCPs. The second pilot involves a formal collaborative agreement with a pediatric practice in Worcester to work more closely together with children under age 6. This pilot is yielding lessons about how the local wraparound process can be adapted to meet the needs of a pediatric practice to improve collaboration with families. The CSA plans to continue both of these projects and to replicate the learning in our North Central CSA. In Project 2, we propose to use DSRIP funds to purchase additional training around these topics to further the goal of improving our coordination with PCPs.

Section 6.3: Populations Served and Community Engagement

A. Member populations and communities Bidder serves
The Community Healthlink CSAs currently serve about 75% of Worcester County. They cover urban, suburban and rural areas. Specifically, the Worcester East and West CSAs serve the cities and towns of Worcester, Auburn, Barre, Berlin, Bolton, Boylston, Brookfield, Clinton, East Brookfield, Grafton, Hardwick, Harvard, Holden, Hubbardston, Lancaster, Leicester, Millbury, New Braintree, North Brookfield, Oakham, Paxton, Princeton, Rutland, Shrewsbury, Spencer, Sterling, Warren, West Boylston, and West Brookfield. The North Central CSA serves the cities and towns of Ashby, Ashburnham, Fitchburg, Gardner, Leominster, Lunenburg, Templeton, Westminster, and Winchendon. The CSAs work with a diverse population in both the North and Worcester. In the greater Worcester area, about 22% of residents are foreign born. The largest ethnicities being Caucasian (59%), Hispanic (21%), African American (12%), and Asian (6%). However, there is a growing African population, and the Worcester public schools are currently

schooling children that speak well over 50 languages. In the North County region, nearly 11% of residents are foreign born, with the largest ethnicities being Caucasian (73%), Hispanic (18%), African American (4%), and Asian (4%).

CHL has several initiatives which assist the CSAs in promoting the health and wellbeing of the individuals we serve. The CSA leadership works closely with our Diversity and Inclusion Initiative and our CLAS (Culturally and Linguistically Appropriate Services) Task Force on creating a welcoming environment and engaging environment for the individuals we serve. These teams monitor track the population in both the Worcester and North Central areas to make sure our CSAs are reaching out to vulnerable populations including new immigrants and those who speak languages other than English. The CLAS task force offers staff trainings in medical interpretation so the agency has in-person translation available when needed. CLAS has recently contracted with a video interpreting service and is completing a pilot study of this initiative. So far, the data indicates that clients highly prefer the video interpreting over telephonic. The plan is to expand this service not only to all CHL sites but also have a mobile version for use in the community. We plan to use some funding for CSA staff to have tablets that can be used for video interpreting so we can better reach and engage individuals whose primary language is not English.

In addition, CHL's Positive Pulse, Wellness Teams and CSA nurse are training staff in holistic views of health and mental health. They are training staff on the ways social determinants of health impact health outcomes. They are also teaching staff skills in how to begin to address prevention of chronic illnesses with families. Currently all clients are encouraged to have at least one wellness goal in the Care Plan. The Worcester CSA has a Quality Improvement Project measuring the impact of the training and wellness goals. We propose to use some of the DSRIP training money to increase staff's knowledge about wellness and health and best practices in communicating and collaborating with PCPs. We believe that good communication with PCPs through electronic record exchange (with proper releases in place) will also impact the health and wellbeing of the youth and families we serve. We are developing materials for ACOs, MCOs and PCPs about the CSAs as a first step in setting forth protocols, points of contact, and ways to exchange information and share treatment goals.

B. Relationships within the community

Community Healthlink's three CSAs have long standing working relationships and contracts with all of the child serving state agencies (DCF, DMH, DPH, Juvenile Courts and Probation, DDS) as well the other behavioral health providers in the area. Leadership meets regularly with DCF and DMH in both areas.

Staff from the CSA continually foster and grow connections within the communities in the Worcester Area and in North Central Massachusetts. CHL and LUK have a long history of working with local collaborations in order to effect change and address health inequities. For example, since 2000, CHL has been the lead agency for the Together For Kids Collaborative (TFK) which consists of thirty providers including child care, mental health, and state agencies; parents and family members; higher education representatives; and funders. Our Worcester CSA is working collaboratively with TFK and Worcester DPH on an integration pilot geared toward youth under age 6. Our agencies' active participation in coalition activities with the CHNAs and Joint Coalition on Health (NC) expands our network of referrals and increases collaboration. In addition, our two Central MA System of Care Committees are well attended by local providers

and state agencies and include representatives from Central MA PPAL and the Autism Resource Center.

Our work with the two Family Resource Centers leads to collaborations as well as our outreach to Centros, South East Asian Coalition and the Spanish American Center in Leominster. Newly hired staff from the communities we serve add their experience and knowledge of resources. Staff attend community events – particularly ones that celebrate diversity and culture – and these add resources to our base of connections. We have close collaborations and shared contracts with both with Family Health Center in Worcester and Community Connections in North Central. We expect through the procurement process to learn more about the services and ways to collaborate with the ACOs and MCOs and the Community Partnerships. In all these ways we will grow the network of community connections to better serve the individuals receiving our service.

We anticipate that our proposed projects will help strengthen our existing partnerships and help forge new ones.

C. How current and planned partnerships align with Bidder's proposed project

Project 1: Electronic Health Record: It is anticipated that a more functional EHR will improve the CSA's ability to track youth and family outcomes. This will enhance our work with our system partners by assisting them to successfully execute their mandates with families. Our experience is that collaboration can be strained when disagreements arise between CSA staff and other system staff. For example, a DCF worker, ICC, and a parent may all disagree as to how a youth is progressing in the program. This tends to occur more frequently when the team is not using good tracking mechanisms to gauge progress and outcomes. We are hopeful that the ability to more rigorously track outcomes through our EHR will increase coordination, and thereby strengthen families' collaboration with all their providers and system partners. In addition, our new EHR will be able to interface through the Mass HIway with PCPs and medical practices which will enhance our care coordination.

Project 2: Staff Training Project: We have proposed to use funding to purchase training for CSA supervisory and front line staff to improve our work with special populations. It is anticipated that this training will build our internal capacity to train future staff in these topics, thereby improving our effectiveness with such groups. Examples include Early Childhood, Transition Aged Youth, LBGTQ youth, Refugee families, and families with returning Veterans. We also expect to provide training which will further our effective collaboration with primary care and medical professionals. Training topics will include professional cultural differences between medical and behavioral health systems, and ways to tailor the CSA Wraparound process so that medical professionals can more fully participate in the process.

Project 3: Mobile Technology Project: We are proposing to use funding to provide CSA staff with better mobile equipment in the field. We plan to train and implement the use of video translation/interpretive services as a means of enhancing the quality of our work with families who require ongoing translation. We believe also that the ability of staff to access the internet in the field will enhance work with families. First, families will be able to play a greater role in their written documents (assessments, care plans) if staff are able to make changes and updates in real time with the family in their home. Second, many tasks that may appear on a Care Plan may involve accessing the internet for information. Staff will now be able to accomplish these tasks with the family in the moment, rather than need to return to the office to access a computer. It is

anticipated that the ability to work with families in real time when we are with them will enhance engagement and accelerate some of the completion of Care Plan tasks.

Project 4: Recruitment: We anticipate that our partnerships with primary care will increase and strengthen over the coming year. With that could come an increase in referrals to the CSA. It is important that the CSA be able to keep up with the increased demand with enough ICC and Family Partners on staff to serve the families who need the program. We are proposing to use some of these funds to enhance the CSA recruiting efforts in an attempt to create new pathways to the CSA for prospective employees. Funds will be used to enhance online visibility for open CSA positions, better advertisement of the benefits of working in a CSA, and the development of recruitment materials.

Project 5: Video Conferencing: We believe that the conferencing capability at our four sites will make it possible for us to share resources, trainings and have case consultation regularly without the travel added. We are also hoping to develop this technology so that PCPs and outpatient clinicians can “attend” team meetings virtually.

Section 6.4 Proposed project(s) and Investment Plan

Project 1: Electronic Health Record

A. Project 1 Description

1. Name or title of project: **Electronic Health Record**

2. Specific goal advanced by the project: Community Healthlink (CHL) proposes to use DSRIP funding to develop and implement a fully electronic health record for the CSAs to strengthen fidelity to Wraparound processes. This new Electronic Record will allow staff to be more closely and efficiently monitored relative to the quality of their work and the timeliness in which ICC and Family Partner services are delivered to families. In addition, the record will connect to the MA HIway and will allow for more effective electronic communication and therefore increase integration with ACOs and PCPs.

3. Scope of project: CHL will have a signed agreement with Qualifacts by the end of July 2017 for the implementation of CareLogic across all CHL behavioral health programs. Planning for implementation has already begun. The goal is for all CSA staff to be trained on the new EHR by 3/31/2018, and all CSA staff using the fully implemented EHR by 5/31/18. Development includes designing work flows, forms, data to be collected, quality management tools, report generation, and billing interface. By May, 2018, the CSA staff should be able to use Qualifacts for all required paperwork. In Period 1, DSRIP funding will be used to connect with the clinical "golden thread" the Assessment, Care Plan and Progress note and develop additional reports on quality measures. During this time, we will also run tests of the Mass HIway functions.

4. Proposed deliverables:

- A complete electronic health record that ICC and Family Partners will use to document all aspects of their work with youth and families including all Assessments, Care Plans, and Transition Plans.
- Systems within the EHR that assist staff to know when required processes and documents are due.
- Systems within the EHR that allow supervisors to easily run regular reports to monitor compliance with required processes and documents.
- Systems within the EHR that improve the quality of supervision of staff by allowing more efficient review of key elements of the record for quality.
- Connection to the MA HIway and communications established with ACOs and PCPs.
- Reports the reflect quality measures and outcomes

5. Specific use of DSRIP funding: The CSAs are approximately 7% of the CHL's revenue. We are proposing to use Preparation Budget DSRIP funding toward the CSA portion of the Qualifacts implementation costs. The estimate of that initial CSA cost is $112,835. In addition, we propose to use an estimated $82,765 in Budget Period 1 for the development of specific CSA required quality tools and reporting.

6. Existing internal resources: Moving to a new EHR requires significant dedicated time from Leadership, IT, Finance, Legal and Compliance. Individuals involved in this projected are listed below. CHL is providing the internal resources to develop and staff the implementation of this project. We are not proposing to charge staff costs to DSRIP funds.

7. How funds will be allocated: In this proposed project the funds requested will be used toward the CSA's portion of CHL's Electronic Medical Record's development. While the contract with Qualifacts does not specify charges per program, we can allocate charges per program based on each program's annual budget. That is what we have done in this proposal. All three CSAs will benefit equally from this initiative. The development will be the same across the sites.

8. Internal evaluation strategies: The Director of the CSA programs at CHL will be responsible for evaluating the effectiveness of this project. This evaluation will include: 1) the assessment of compliance by staff for all required paperwork; 2) The quality of Assessments and Safety Plans; and 3) the development of outcome data for youth enrolled in the CSAs. Currently, compliance by staff for required paperwork is documented by a monthly report. Performance on this report has indicated compliance rates between 70% and 90% over the past year. We anticipate that the EHR will "go live" in March/April of 2018. The first measurement period for overall compliance will be June, 2018. Because the EHR will provide staff with real time reminders and tracking assistance, we hope to achieve 95% compliance by September, 2018. Abby Sallila in the North Central CSA and Mandi Robinson in the Worcester East and Wests CSAs will be trained in how to track compliance, and will report this data to the Director of CSA programs (Dr. Anthony Irsfeld) on monthly basis beginning in June, 2018.

Relative to the quality of Assessments and safety plans, currently the program conducts periodic chart reviews to judge the quality of these two documents. With the new EHR, Assessments and Safety Plans can be electronically reviewed by supervisors in real time. The program does not currently have clear baseline data for how many Assessments and Safety Plan meet our standards, but CSA managers estimate that the current number is likely around 75%. Abby Sallila and Mandi Robinson will work with Anthony Irsfeld to set up program procedures for tracking the percentage of acceptable assessments and safety plans in the new EHR by May, 2018. Baseline data will be collected in June, 2018, with goals for improvement established by July, 2018. The goal will be 100% of Assessments and Safety Plans developed by veteran (not newly hired) staff will meet supervisor expectations.

Finally, the new EHR will have embedded within the record an Outcome Measure, which ICC and Family Partners will be required to administer quarterly to enrolled youth and families. We anticipate that this measure will be the Ohio Scales for Youth. Baseline data will be collected on all families beginning in June 2018. Abby Sallila (for the North Central CSA) and Mandi Robinson (for the Worcester East and West CSAs) will oversee the training of staff in the use of the scales and tracking that data is being collected on all enrolled youth. Once each youth has two measurements, the data will be analyzed by Dr. Anthony Irsfeld. This will represent a baseline outcome score for the programs. Once a baseline is established, the program will set target goals for improving these outcome scores if needed. The first set of target goals will be established by October, 2018.

B. Project Team description

1. Organizational chart: See Attachment A: Organizational Charts.

2. List of current staff: The following staff will be involved in the EHR project. See Attachment B: Job Descriptions, which are included for each staff. Job titles and responsibilities for this project are included after each individual. Qualifications are listed for each staff the first time his/her name appears assigned to a project.

- **Michael Rezkalla**, *Vice President, Operations*: Mr. Rezkalla has more than a decade of experience managing operations systems in healthcare settings. Immediately prior to his employment at CHL, Mr. Rezkalla served as the Division Operations Manager at Upham's Corner Health Center. Mr. Rezkalla oversees the contract with Qualifacts and the technical aspects of this project including issues around security and HIPPA compliance.
- **Michael Blair,** *Director of Information Technology*; Mr. Blair has held progressively responsible jobs in IT at CHL since 1980. He has extensive experience in EHR implementation and development and in data management and reporting. CHL's parent organization, is providing technical assistance in the implementation of the new EHR, including IT consultation. Mr. Blair is assigned to this project to work collaboratively with UMass MIS department and Qualifacts in implementing this new EHR across the agency – including the three CSAs.
- **Carolyn Droser,** LICSW: *Vice President for Children's and Emergency Services:* Ms. Droser has 30 years of experience overseeing adult and child behavioral health programs. Currently she is responsible for CHL's 20 child serving programs, the Emergency Services Teams and the Integrated Care Management Department. Ms. Droser is responsible for the successful implementation of the clinical component of the EHR.
- **Anthony Irsfeld Ph. D.**, *Director of Families and Communities Together* (CHL's CSAs): Dr. Irsfeld has over 25 years' experience in child and family behavioral health. He has experience with Electronic Health records, having helped develop early Wraparound prototypes with the Communities of Care Initiatives at UMAS Medical School. He has been a trainer and coach of the Wraparound model for over 10 years, and has overseen the CHL CSAs since their launch in 2009. Dr. Irsfeld is responsible for the development of the work flow, forms and quality component of the CSA EHR record.
- **Tom Hall**, *Operations Director of LUK, Inc*.: Mr. Hall has been the Chief Operations Officer at LUK, Inc for the past 22 years. In this role, he takes primary responsibility for marketing and development initiatives, contracting, program development and implementation, and oversight of the organization's MIS systems and technology departments. He was part of the original FCT Steering committee and has been a strong community advocate for CSA services since the launch of the program in 2009. Mr. Hall will oversee operational aspects of LUK's use of the new EHR.
- **Tamara Durr**, *Chief of Staff*: Tamara Durr has more than three years' experience as the Chief of Staff/Director of Special Projects at CHL. Immediately before working at CHL, Ms. Durr served as an Administrative Fellow at UMass Memorial Health Care. Ms. Durr has a Master of Health Administration Degree as well as a Master of Social Work degree, both from The Ohio State University. UMass Memorial Health Care (UMMHC), CHL's parent organization, is providing technical assistance in the implementation of the new EHR including project management. Ms. Durr oversees CHL's Project Management department and will be assigned to the project management team for this CSA DSRIP project.
- **Abigail Sallila, LMHC**, *Director of ICC for North Central CSA***;** Ms. Sallila has been working within the CSA for over 5 years, first as an ICC, then as an ICC supervisor, and now as the Director of ICC services for the North Central CSA. She is a strong advocate for high-fidelity Wraparound practice.

- **Mandy Robinson, LMHC**: *Director of ICC for Worcester East and West CSAs*; Ms. Robinson has been working within the CSA for over 6 years, first as an ICC, then as an ICC supervisor, and now as the Director of ICC services for the Worcester East and West CSAs. She is a strong advocate for high-fidelity Wraparound practice.
- **Janice Rose**, *Director of Family Partner and Training for Worcester East and West CSAs*: Janice Rose. Janice has nearly 15 years' experience with the Wraparound model and family partner advocacy. Starting first as a Family Partner with the UMASS Communities of Care Initiatives, she was then hired as one of our first Senior Family Partners when the CSAs launched in 2009. For the past 2 years, she has been the Director for Family Partners for the Worcester East and West CSAs.

  Ms. Sallila, Ms. Robinson, and Ms. Rose will work with Dr. Irsfeld and the Qualifacts' team to develop forms and reports for the CSA.
- **Katrin Sanford, LMFT, CHC**, *Director of Compliance*: Ms. Sanford has been in behavioral healthcare for almost 20 years, and is both a Licensed Marriage and Family Therapist and Certified in Healthcare Compliance, and has experience in both direct care and compliance. Ms. Sanford as the Compliance Officer will ensure that systems are developed that are HIPPA compliant, and that systems are in place to ensure that when bills are produced that the record is compliant in all respects.
- **John Lito**, *Chief Financial Officer*: Mr. Lito has been providing hands-on fiscal management and analysis to organizations for over 15 years, including profit and loss responsibility and the development and implementation and integrated financial management reporting systems and procedures. Mr. Lito will work with the Qualifacts and CHL billing teams to ensure that the new system is able to bill MassHealth and DMH (Caring Together contract) effectively for the CSA services.

3. Any staff Bidder proposes to hire: We are not proposing to hire any staff or charge any staff to this project through DSRIP funds.

4. Roles and responsibilities: The roles and responsibilities of each of the staff involved in this project are defined in #2 above. Each person involved was selected because of his/her qualifications, role within CHL and because they are content experts. There is representation from each major CHL operation related to this project – IT, Finance and Compliance – in addition to Administration and the CSAs.

5. How Bidder will manage project(s): CHL's Project Management Department is under the leadership of Tamara Durr. She will be responsible for the project management of the CSA DSRIP funds. The Department was involved in the development of the project's timeline and will utilize their management resources to track progress in meeting the project goals. Ms. Droser and Dr. Irsfeld will work closely with the project management team so that information is available for the semi-annual and annual Progress Reports to EOHHS.

C. Implementation Plan and Timeline
See Attachment C: Implementation Plan and Timeline.

D. Budget Report and Budget Narrative
See Attachment D: Budget Report, and Attachment E: Budget Narrative.

E. Sustainability

These funds will help develop the EHR's capacity for CSA specific forms, systems, and reports. We expect to utilize DSRIP funds for this project in the Preparation Budget Period and during Budget Period 1. Once developed, Community Healthlink/CSAs will continue to support the EHR after implementation as part of its ongoing operating budget.

Project 2: Staff Training

A. Project 2 Description

1. Name or title of project: **Staff Training**

2. Specific goal advanced by the project: This training project will assist in the integration with ACOs and primary care providers for ICC-Engaged youth and their families. Specifically, through this project we propose to obtain outside consultation and in-service training around specific topics pertaining to better engagement and care coordination with special populations and improved coordination and collaboration with medical professionals—especially pediatric primary care.

3. Scope of project: The CSA plans to develop a list of in-service training topics and a training calendar for each calendar year beginning with 2018. Staff and CSA managers will annually utilize supervision, staff meetings and Idea Boards to develop a list of in-service training topics they feel most affect quality. CSA mangers will construct a training calendar for each year beginning with 2018 address these topics. Included within these topics will be training around working with pediatric practices, and improving collaboration with other medical professionals. When possible, we will use train-the-trainer models and video-tape presentations to aid with ongoing sustainability. We propose to use DSRIP funds toward training each year of DSRIP funding.

4. Proposed deliverables:

- A year-long training calendar (each year 2018-2022) to address topics of special populations and increased coordination with pediatric primary care based on staff and program needs.
- Development of training materials on the above topics for future and ongoing training when funds are no longer available to purchase outside training.

5. Specific use of DSRIP funding:

- Funding will be utilized to support trainings on topics developed by staff and management that will develop skills in working with specific populations and teach Best Practices in coordinating care with ACOs, MCOs and PCPs.

We have allocated $ 4000 to this project in the Preparation Budget and $5000 in Budget Period 1 and 2. In the following years, we have allocated: $3,000 in Budget Period 3; and $2,000 in Budget Periods 4 and 5.

6. Existing internal resources: Dr. Anthony Irsfeld will work with existing CHL and LUK CSA managers using existing LEAN Quality Improvement tools and processes to develop and implement this training plan.

7. How funds will be allocated: We will ensure that each CSA has equal access to in-service programs. The Leadership Team (Directors and Supervisors of the three CSAs – including LUK managers) will collaborate on the in-service training plan for the three CSAs. We will a set-up in-service program to meet unique needs of a CSA (for instance, working with African Refugees

in Worcester) when that is necessary. When trainings scheduled have available slots, other CHL and LUK CBHI providers will be invited to attend.

8. Internal evaluation strategies: Once implemented, the CSA will use its LEAN QI tools to solicit ongoing feedback to CSA managers about the quality and usefulness of in-service training received. Currently, the program is tracking the number of Care Plans that include a health/wellness related goal or task. In North Central (who just began to track this data), approximately 10% of Care Plan contain a health/wellness goal or task. In the Worcester CSAs (who have been working on this data for the past 18 months), 57% of Care Plans contain health/wellness goal or task. We hope that with increased training of staff around improving collaboration skills with pediatric and primary care providers, these data will reach our goal of 85% of Care Plans will contain a health/wellness goal or task. The CSA programs are already tracking this data on a quarterly basis. Dr. Anthony Irsfeld will continue to work with Abby Sallila and Mandi Robinson to monitor this data as an indicator that the training provided is having the intended effect. In addition, with the implementation of an addition Outcome Measure (see above), the program will be able to monitor progress relative to health and wellness.

B. Project Team description

1. Organizational chart: See Attachment A: Organizational Charts.

2. List of current staff: The following staff will be involved in the EHR project. See Attachment B: Job Descriptions, which are included for each staff. Job titles and responsibilities for this project are included after each individual. Qualifications are listed for each staff the first time his/her name appears assigned to a project.

- **Dr. Anthony Irsfeld**, *Director of CSAs*: Dr. Irsfeld will facilitate discussions with the CSA leadership in developing in-service training topics and arranging for trainers.
- **Sarah Loy**, *Director of Development and Communication:* Ms. Loy has more than ten years of experience in the fields of non-profit fundraising, and grant-writing, and communication, including the creation of both external educational materials (brochures, manuals, videos) as well as internal employee communications.
- **Abigail Sallila, LMHC**, *Director of ICC for North Central CSA***; Mandi Robinson, LMHC**: *Director of ICC for Worcester East and West CSAs*; **Janice Rose**, *Director of Family Partner and Training for Worcester East and West CSAs*;
- **Sandra Mangado,** *Senior ICC LUK North Central CSA*; Ms.Mangado, has been with our North Central CSA since 2012, first as an ICC, and now a Senior ICC overseeing the ICC work at our North Central LUK site in Fitchburg.
- **Torrence Phillips,** *Senior ICC LUK Worcester CSA*: Mr. Phillips has been with our CSA since 2014, first as an ICC, and now as a Senior ICC overseeing the ICC work at our Worcester West LUK site.

These five CSA managers under Dr. Irsfeld's leadership will meet with staff in supervision, staff meetings and in Idea Board huddles to gather a list of topics and skills staff wish to learn to improve their ability to best engage referred youth and families and to work with PCPs and ACOs through best practices.

- **Tamara Durr**, *Chief of Staff*: Ms. Durr will be the project manager for this CSA DSRIP project.

3. Any staff Bidder proposes to hire: We are not proposing to use DSRIP funding for any CSA staff time in this project. The funding for in-service training will be for trainers from outside CHL and LUK.

We will contract with individuals and with organizations to provide training. We have reached out, for example, to Fenway Health regarding the LBGTQ training and to the Center For Health Impact for training in ways to impact chronic illness though wellness activities.

4. Roles and responsibilities: The roles and responsibilities of each of the staff involved in this project are defined in #2 above. Each person involved was selected because of his/her qualifications, role within CHL and because they are content experts. Dr. Irsfeld is the lead on this project and will coordinate the work so there is no duplication of efforts.

5. How Bidder will manage project(s): CHL's Project Management Department is under the leadership of Ms. Tamara Durr. She will be responsible for the project management of the CSA DSRIP funds. The Department was involved in the development of the project's timeline and will utilize their management resources to track progress in meeting the project goals. Ms. Droser and Dr. Irsfeld will work closely with the project management team so that information is available for the semi-annual and annual Progress Reports to EOHHS.

C. Implementation Plan and Timeline
See Attachment C: Implementation Plan and Timeline.

D. Budget Report and Budget Narrative
See Attachment D: Budget Report and Attachment E: Budget Narrative.

E. Sustainability:
While these funds will also be used to hire outside training, the CSA will focus on receiving training materials and "train-the-trainer" models of training so that the program can continue to provide training around these important topics after funds are no longer available. When possible we will video the trainings.

Project 3: Mobile Technologies

A. Project 3 Description
1. Name or title of project: **Mobile Technologies**

2. Specific goal advanced by the project: This Mobile Technology project will strengthen fidelity to the Wraparound processes and increase timely access to ICC services. Specifically, through this project we propose:

- To enable staff to access video translation services so as to enhance the quality of the family's experience when staff do not speak the family's preferred language.
- To provide staff access to the new EHR in real time while in the community with youth and families so that families may take an increased role in their Care Planning process.
- To enable staff access to the Internet so as to complete Care Planning tasks with families in the community in real time.

3. Scope of project: The CSA will use funding to purchase mobile devices that staff may use in the field to accomplish the goals listed above. It is still unclear at this time what type of

technology (tablet vs laptop, type of operating system, cloud vs. server based) will work best with the new EHR CHL is implementing. Thus, by March 31, 2018, CHL will have researched and decided on the type of devices CSA staff will use in the field. These purchases will be made by June 1, 2018. The EHR, which is being developed, will have compatibility with the mobile devices which will allow staff to access important CSA documents when they are in the community with families. We plan to use DSRIP funding to purchase the equipment and in Budget Periods 1-5 we propose to utilize decreasing amounts of funding to support the operation expenses of the mobile devices (i.e. Internet connections).

4. Proposed deliverables:

- Mobile devices for all staff to access in the community when needed by June 1, 2018.
- Training for all staff on the use of the mobile technology including how to access and use video translation services using their mobile device by April 30, 2018.
- Training for all staff in the use of the new EHR with the mobile device by June 1, 2018.
- Training for staff in use of portable printers by June 1, 2018.
- Staff to be regularly using mobile technology with families to assist them in accessing resources; to be accessing video interpreting when necessary and; to be updating Care Plans and writing notes collaboratively with families in the community.

5. Specific use of DSRIP funding: We are proposing to spend an estimated $90,000 on mobile technology in the Preparation Budget. That will include Laptops or Tablets and software for each of the CSA staff which includes signature pads or signature capability on the tablet at an average of $1400 per staff at $81,200. There is a cost of $1736 for LoJack for these devices; software which tracks and prevent theft. We will purchase two portable printers per CSA site (two CHL; Two LUK) at a cost of approximately $2064. We propose to purchase 25 cell phones at approximately $200 each for an additional $5000.

We have some smaller equipment purchases allocated for Budget Periods 2 ($16,000) and 3 ($5580) due to expected program expansion given the closer collaboration we expect to have with the ACOs and PCPs.

We are proposing to allocate funds in Budget Periods 1-5 to support the costs of ongoing mobile technology – cell phone charges and Internet access. These new devices will add significant additional costs across the CSAs per year. We propose to allocate $$50,000toward these costs in Budget period 1; $73,300 in Period 2; $49,080in Period 3; $41,000in Period 4 and $15,700in Period 5.

6. Existing internal resources: CSA management will collaborate with CHL IT to choose durable equipment that meets the needs of the program, is compatible with Qualifacts and is effective in the field. IT and CHL's purchasing Department will be responsible for purchasing the equipment. IT is responsible for setting up and encrypting the Laptops/Tablets. IT will also provide necessary training. Project management staff will provide the training on video interpreting.

7. How funds will be allocated: All three CSAs will receive equipment based on the number of staff at each site. All staff will have access to mobile technology. Each site will receive portable printers. Cell phones will be distributed to staff that do not currently have cell phones.

8. Internal evaluation strategies: Once implemented, the CSA will use its LEAN QI tools and processes to solicit ongoing feedback from staff about the effectiveness and usefulness of the mobile devices in providing ICC and Family Partner services. Specifically, Abby Sallila (for the North Central CSA) and Mandi Robinson (for the Worcester CSA) will track staff satisfaction with the mobile devices. The goal will be that by December of 2018, 80% of staff report that the mobile device enhances their work with families in the field. Relative to the use of video translation services, the CSA program will be adding an item to its Client Satisfaction Survey which specifically asks those families who needed and used a translator about their satisfaction with the experience. Abby Sallila and Mandi Robinson will be responsible for ensuring that those staff who use this service administer the Client Satisfaction Surveys to those families. The goal will be that 85% of families report good to very good satisfaction with translation service they received. This data will be collected on an ongoing basis.

B. Project Team description

1. Organizational chart: See Attachment A: Organizational Charts.

2. List of current staff: The following staff will be involved in the EHR project. See Attachment B: Job Descriptions, which are included for each staff. Job titles and responsibilities for this project are included after each individual. Qualifications are listed for each staff the first time his/her name appears assigned to a project.

- **Michael Rezkalla**, *Vice President, Operations*: Mr. Rezkalla will assist in the selection of the Laptops/tablets and portable printers for this project. He is also responsible for the Purchasing Department and will help to develop and track the purchase orders.
- **Michael Blair:** *Director of Information Technology*; Mr. Blair is responsible for the set-up and encryption of each device. He will provide training and orientation as needed to the devices.
- **Carolyn Droser,** LICSW*, Vice President for Children's and Emergency Services*: Ms. Droser will oversee this Mobile Technology initiative and coordinate this project with IT, LUK and CSA management
- **Dr. Anthony Irsfeld**, *Director of CSAs*: Dr. Irsfeld is responsible for the quality measures related to this initiative.
- **Tom Hall,** *Operations Director of LUK, Inc*.: Mr. Hall will be the Operations contact for this project with LUK, Inc.
- **Tamara Durr**, *Chief of Staff*: Ms. Durr will be assigned to the project management team for this CSA DSRIP project. She will ensure that staff are trained in the use of the Video Interpreting technology and that we are able to receive reports on the use of the technology.
- **Abigail Sallila, LMHC**, *Director of ICC for North Central CSA***; Mandi Robinson, LMHC**: *Director of ICC for Worcester East and West CSAs*; **Janice Rose**, *Director of Family Partner and Training for Worcester East and West CSAs*; **Sandra Mangado,** *Senior ICC LUK North Central CSA*; and **Torrence Phillips,** *Senior ICC LUK Worcester CSA*: These five managers will assist staff with the orientation to mobile technology and make certain that all staff are trained in all compliance and HIPPA related aspects of the technology

- **Katrin Sanford, LICSW**, *Director of Compliance*: Ms. Sanford will ensure that the devices are HIPPA compliant and that staff are knowledgeable about all CHL protocols regarding mobile technology.

3. Any staff Bidder proposes to hire: CHL does not propose to hire any staff to implement this project.

4. Roles and responsibilities: The roles and responsibilities of each of the staff involved in this project are defined in #2 above. Each person involved was selected because of his/her qualifications, role within CHL and because they are content experts.

5. How Bidder will manage project(s): CHL's Project Management Department is under the leadership of Ms. Tamara Durr. She will be responsible for the project management of the CSA DSRIP funds. The Department was involved in the development of the project's timeline and will utilize their management resources to track progress in meeting the project goals. Ms. Droser and Dr. Irsfeld will work closely with the project management team so that information is available for the semi-annual and annual Progress Reports to EOHHS.

C. Implementation Plan and Timeline
See Attachment C: Implementation Plan and Timeline.

D. Budget Report and Budget Narrative
See Attachment D: Budget Report and Attachment E: Budget Narrative.

E. Sustainability:
These funds will support the initial purchase of a large number of devices for CSA staff to use when they are in the community. Over time, Community Healthlink and LUK will assume responsibility for the ongoing expense of replacing devises gradually each year as they fail, need updating, etc. as part of the CSA's equipment budget line.

Project 4: Recruitment

A. Project 4 Description

1. Name or title of project: **Recruitment**

2. Specific goal advanced by the project: This Recruitment project will increase timely access to ICC services. Specifically, through this project we propose:

- To increase the volume of qualified candidates for employment at the CSA.
- To increase the diversity—especially as it pertains to languages spoken—of qualified candidates for employment to the CSA.

3.Scope of project: The CSA proposes to use Preparation Budget DSRIP funding to augment current recruitment efforts in three ways. First both LUK and CHL propose to allocate funds to increase online presence on Indeed and Monster.com. Secondly, the CSA will work with the CHL HR and Development Departments department to produce and translate more targeted recruitment materials into Spanish to help with recruitment of Spanish speaking ICC and Family Partners.

Third, funding will be used to support job fairs and recruiting events with a special outreach appeal for bilingual and bicultural candidates. In the Preparation Budget period will hold one event with a NC focus in early December and one with a Worcester area focus in February. We will work collaboratively with CENTRO in Worcester and Spanish American Center in

Leominster so that materials about the job openings are distributed within the communities these agencies serve.

In following Budget Periods we have allocated funds to this recruitment project – both for the costs related to increasing our online presence as well as for Job Fairs. These amounts may increase or decrease depending on CHL/LUK CSA workforce needs are at that time.

4. Proposed deliverables:

- Materials to distribute about jobs in the CSA in English and Spanish by March, 2018
- Increase in qualified applicants for CSA jobs
- More diverse qualified applicants for CSA jobs—especially as it pertains to languages spoken.

5. Specific use of DSRIP funding: Priority postings on Indeed are estimated to be $200/month agency. During Preparation Budget Period the total cost for those postings for CHL and LUK would be $2,000. Monster.com costs are $800/month per agency. During Preparation Budget Period that would total $8,000 for CHL and LUK. Translation of job postings/descriptions into Spanish by Center For Health Impact is estimated to be $1,500. We propose to support the Job Fair costs with DSRIP funding of light refreshments, space and materials. We estimate those costs to be approximately $1,000. There will be two fairs during the Preparation budget period which totals $2,000.

We have allocated funds for this project through all budget periods in order to continue recruitment efforts. We will adjust how the funds are used based on the success of the various initiatives.

6. Existing internal resources: The CSA will work closely with the CHL and LUK HR and Recruiters on this project. HR staff will gather data describing how the candidate became aware of the agency position so that we are able to track the use of both the online enhancements as well as job fairs.

7. How funds will be allocated: Funds will be allocated to the three CSAs and to LUK and CHL. LUK and CHL will receive the same allocations for Monster and Indeed on-line recruitment. The Worcester area and North Central area will each have a job fair located in their region.

8. *Internal evaluation strategies:* The CSAs currently receives approximately 1-3 resumes for open ICC positions. Our goal through these new recruitment efforts will be to increase the number of qualified candidates to 3-5 per open position by August 2018. Mandi Robinson and Abby Sallila will track this data as part of the interviewing and hiring process. They will also track which strategies (materials, recruiting events, job-seeking websites) seem to be most effective in attracting quality applicants.

B. Project Team description

1. Organizational chart: Please see attached Organizational Chart for the Recruitment Project.

2. List of current staff: The following staff will be involved in the EHR project. See Attachment B: Job Descriptions, which are included for each staff. Job titles and responsibilities for this project are included after each individual. Qualifications are listed for each staff the first time his/her name appears assigned to a project.

- **Joe Lavin,** *Vice President for Human Resources*: Joe Lavin has been working in the HR arena since 1996 in various positions. Prior to joining CHL he held the positions of HR Manager, HR Director and Plant Manager in a manufacturing facility that has Union and non-Union members. In August of 2009 he joined CHL as Director of HR and in October of 2014 was promoted to VP of Human Resources. Mr. Lavin will oversee the contracts for CHL with Monster.com and Indeed. He will also supervise the work of Michelle Popp.
- **Michelle Popp,** *Recruiter*: Michelle Popp, Recruiter, has more than 15 years' experience in Human Resources, including more than ten years as a recruiter. Prior to working at CHL, Ms. Popp served as a recruiter at Staples and at several healthcare related staffing firms. Ms. Popp will work with the CSA managers on the development of a plan for the Job Fairs. This includes the development of the recruitment job descriptions and qualifications that we will have translated into Spanish.
- **Sarah Loy**, *Director of Communications and Resource Development*: Ms. Loy will design the materials (graphics and layout) for distribution and work with Center for Health Impact on the translation of the materials.
- **Carolyn Droser,** *LICSW: VP for Children's and Emergency Services*: Ms. Droser will oversee this Recruitment initiative and coordinate this project with LUK, Development, HR and the CSAs.
- **Dr. Anthony Irsfeld**, *Director of CSAs*: Dr. Irsfeld is responsible for the quality measures related to this initiative.
- **Tom Hall,** *Operations Director of LUK , Inc*.: Mr. Hall will be the Operations contact for this project with LUK, Inc.
- **Tamara Durr**, *Chief of Staff:* Ms. Durr oversees CHL's project management department and will be assigned to the project management team for this CSA DSRIP project.
- **Abigail Sallila, LMHC**, *Director of ICC for North Central CSA***; Mandi Robinson, LMHC**: *Director of ICC for Worcester East and West CSAs*; **Janice Rose**, *Director of Family Partner and Training for Worcester East and West CSAs*; **Sandra Mangado,** *Senior ICC LUK North Central CSA*; and **Torrence Phillips,** *Senior ICC LUK Worcester CSA*: These five managers will assist in the development of recruitment materials and in staffing the job fairs.

3. Any staff Bidder proposes to hire: CHL does not propose to hire any staff in this project. We will contract with Center for Heath Impact for translation of materials and with Indeed and Monster.com.

4. Roles and responsibilities: The roles and responsibilities of each of the staff involved in this project are defined in #2 above. Each person involved was selected because of his/her qualifications, role within CHL and because they are content experts.

5. How Bidder will manage project(s): CHL's Project Management Department is under the leadership of Tamara Durr. She will be responsible for the project management of the CSA DSRIP funds. The Department was involved in the development of the project's timeline and will utilize their management resources to track progress in meeting the project goals. Ms. Droser and Dr. Irsfeld will work closely with the project management team so that information is available for the semi-annual and annual Progress Reports to EOHHS.

C. Implementation Plan and Timeline
See Attachment C: Implementation Plan and Timeline.

D. Budget Report and Budget Narrative
See Attachment D: Budget Report and Attachment E: Budget Narrative.

E. Sustainability
These funds will support the development of improved recruiting materials that once created, will continue to be used at relatively little cost. Realizing that once funds are no longer available, we may not be able to continue to support a more expensive on-line presence or frequent recruiting events, we hope to use the funding period to learn which strategies appear most effective, so that going forward are using existing agency resources to maximum benefit.

Project 5: Video Conferencing

A. Project 5 Description
1. Name or title of project: **Video Conferencing Project**

2. Specific goal advanced by the project: We are proposing to develop the capacity for all CHL/LUK CSA supervisors to effectively meet on a regular basis to share best practices, discuss quality initiatives, and develop greater consistency with respect to performance expectations. We are including this project because we believe it will increase communication and lead to greater efficiency of our leadership and thus contributing to strengthening of fidelity to the model. With four scattered sites the ability to gather without traveling is much more efficient.

3. Scope of project: The CSA plans to purchase and install video conferencing equipment by December, 2017. All staff will be trained in its use, and a regular meeting schedule among the CHL-LUK CSA supervisors will be in place by March, 2018.

4. Proposed deliverables:
- A regular meeting schedule among all CHL-LUK CSA supervisors
- Better consistency of supervision across sites
- More consistent performance of CSA staff across sites

5. Specific use of DSRIP funding: We propose to purchase 4 Polycom portable monitor, camera and computer units at $1500 a unit. We would install one at 99 Day Street and 545 Westminster St. for LUK staff and management and one at 100 Erdman Way and one at 199 Chandler St. for CHL sites.

6. Existing internal resources: CHL and LUK IT staff will purchase, install and train staff on the use of this equipment.

7. How funds will be allocated: The funds are being allocated equally to CHL and LUK and the CSA sites.

8. Internal evaluation strategies: The Director of the CSA programs at CHL, Dr. Anthony Irsfeld, will be establishing a process for more reliably tracking youth and family outcomes (see EHR project description). By October, 2018, data from the new outcome measure will have been analyzed. This will serve as our baseline data. Part of this analysis will be to compare outcome scores among the CSA sites. It is expected that with more regular and consistent communication among all CHL-LUK CSA supervisors, outcome data will demonstrate

increasingly consistent performance across the sites. To the extent that the baseline outcome scores differ, the CHL-LUK supervisors will utilize this equipment to meet together to establish performance goals relative to this outcome measure. In addition, Anthony Irsfeld will use the LEAN model of quality improvement to track supervisor satisfaction with the project and their ideas for improvement of the project as it is implemented. The goal will be to have 90% of all supervisors satisfied with the use of the equipment and resulting meetings by December 2018.

B. Project Team description

1. Organizational chart: Please see Organizational Chart for this Video Conferencing Project

2. List of current staff: The following staff will be involved in the EHR project. See Attachment B: Job Descriptions, which are included for each staff. Job titles and responsibilities for this project are included after each individual. Qualifications are listed for each staff the first time his/her name appears assigned to a project.

- **Michael Rezkalla**, *Vice President, Operations*: Mr. Rezkalla will assist in the purchase and supervise the installation of the equipment.
- **Michael Blair,** *Director of Information Technology*; Mr. Blair will be responsible for the installation and set-up of the equipment. He will train the managers at each site in the use of the equipment.
- **Carolyn Droser,** *LICSW: VP for Children's and Emergency Services*: Ms. Droser will oversee this Video Conferencing initiative and coordinate this project with IT, LUK and CSA management.
- **Dr. Anthony Irsfeld**, *Director of CSAs*: Dr. Irsfeld is responsible for the quality measures related to this initiative.
- **Tom Hall:** *Operations Director of LUK, Inc.*: Mr. Hall will be the Operations contact for this project with LUK, Inc.
- **Abigail Sallila, LMHC**, *Director of ICC for North Central CSA***; Mandi Robinson, LMHC**: *Director of ICC for Worcester East and West CSAs*; **Janice Rose**, *Director of Family Partner and Training for Worcester East and West CSAs*; **Sandra Mangado,** *Senior ICC LUK North Central CSA*; and **Torrence Phillips,** *Senior ICC LUK Worcester CSA*: These five managers will be trained in the use of the equipment and will train other managers at sites in the use of the video conferencing equipment.
- **Tamara Durr**, *Chief of Staff*: Ms. Durr will be assigned to the project management team for this CSA DSRIP project.

3. Any staff Bidder proposes to hire: CHL does not propose to hire any staff to implement this project.

4. Roles and responsibilities: The roles and responsibilities of each of the staff involved in this project are defined in #2 above. Each person involved was selected because of his/her qualifications, role within CHL and because they are content experts.

5. How Bidder will manage project(s): CHL's Project Management Department is under the leadership of Ms. Tamara Durr. She will be responsible for the project management of the CSA DSRIP funds. The Department was involved in the development of the project's timeline and will utilize their management resources to track progress in meeting the project goals. Ms.

Droser and Dr. Irsfeld will work closely with the project management team so that information is available for the semi-annual and annual Progress Reports to EOHHS.

C. Implementation Plan and Timeline
See Attachment C: Implementation Plan and Timeline.

D. Budget Report and Budget Narrative
See Attachment D: Budget Report and Attachment E: Budget Narrative.

E. Sustainability:
These funds will help with the initial purchase of the equipment necessary to have functional video conferences. Over time, Community Healthlink will assume responsibility for the ongoing expense of replacing devices gradually as needed as part of the CSA's equipment budget line.

Section 6.5: Coordination with ACOs, MCOs, and Primary Care Providers

A. Bidirectional communication

Communication across disciplines, agencies, geography, and electronic records is complicated and we expect to continually review and improve our information exchange process through our QI processes.

As part of our start-up both for the CSA initiative and CHL's Community Partnership (CP) program (if awarded), CHL will set-up a team of managers from the CSAs and CP focused on establishing communication protocols with the ACOs, MCOs and PCPs. Our goal is to have clear consistent lines of communication for questions, referrals and coordinating care for adults and children. The systems are complicated and it is important to us that the ACOs, MCOs, and PCPs know what services we provide, who is eligible for the service, how to make a referral, and what the expectations are after the referral has been made. Through written materials such as brochures and pamphlets, we will provide attractive, easy-to-understand information about how the ACOs, MCOs and PCPs can benefit from a relationship with CHL.

We also plan to have face-to-face meetings with ACOs, MCOs, and pediatric and family practices with whom we frequently interact. Through face-to-face meetings, we plan to both learn about particular needs as they relate to our CSA services and share with the ACOs and MCOs information about who we are and the ways in which we can help meet the needs of their patients.

As part of this proposal, we also expect to provide all CSA staff training which will further their ability to effectively collaborate with primary care and medical professionals. Training topics will include professional cultural differences between medical and behavioral health systems, and ways to tailor the CSA Wraparound process so that medical professionals can more fully participate in the process. This learning has already begun through our current SAMHSA funded pilot project with the Worcester Plumley Village Family Practice. For example, we are experimenting with good success different ways of maintaining frequent and functional bi-directional communication with the youth's PCP while also honoring the core Wraparound principle of "nothing about us without us."

We currently have good communication with our other partners and Care Planning Team members. Our new EHR will be able to receive and send documents via the MA HIway which should increase that communication not only between the medical professionals and the CSA staff but also with other providers. For community agencies, state agencies, and natural supports, we will also exchange information and updates thorough regular telephone contacts, secure email, and by fax. In all situations, we will ensure that we have in place appropriate and valid ROIs.

Finally, all of CHL will be on the new EHR. The system has "tasking" and "messaging" functions so that the communication between CHL's CSA staff and other programs – In Home Therapy, MCI, outpatient, CBAT etc. – is efficient and in real time. This will improve care coordination and communication significantly.

B. Referral management protocols

Our plan for the CSAs will be to continue what has worked very well to date. The Administrative Assistant at each CSA site will be responsible for taking initial calls from the medical providers. They are trained to answer basic questions about the CSA service and eligibility. For more complex discussions, the AA is able to refer the call—usually immediately-- to a CSA manager.

In the event a medical provider must leave a message, the CSA has a good track record of getting back to referral sources in the same day or next day in the event the call comes in after hours. After a provider makes a referral, the family contact information is forwarded to a CSA manager who contacts the family within 24 hours and in that call describes the program, answers questions, determines eligibility and obtains consent.

The Central Massachusetts Accountable Care Organization with Tufts Health Public Plans which is in our region has already reached out to us about their decision to use Aunt Bertha, Inc. as a platform for a resource for the ACOs and CPs to use to help connect individuals to community resources. Our CSAs will make certain that the information about our services and referral processes are clear and usable so that ACO staff who use the platform will have easy access to our information. Should it be necessary to amend or change any aspect of our CSA referral process to better accommodate PCPs or the ACOs, the CSA leadership will use our quality improvement tools in place to make those changes.

We understand that we will need to engage and collaborate with multiple ACOs and MCOs in the Worcester and Gardner-Fitchburg Service Areas, and we plan to hold introductory meetings with the administrative teams of each of the ACOs and MCOs to learn about their health care services and each organization's distinct needs. In these meetings we will provide information on the CSA services and referral process

C. Team-based treatment planning

We see the ICC as the hub for communication among stakeholders. Regular communication with each member of the youth's Care Planning Team is a primary responsibility of the CSA ICC. One of the challenges to date has been how to develop meaningful participation of the youth's PCP with the CSA Care Planning process. We feel that the training proposed here will help our CSA staff to better understand the needs of primary care physicians, to improve their skill around helping the physicians understand and better appreciate how the CSA process can benefit them, and to help CSA staff better tailor the Care Planning process to make it easier for physicians to have meaningful participation

D. Timely access to ICC services

Our Development Plans and our proposal for DSRIP funding both address the need to successfully recruit and retain ICC and Family Partner staff. We see recruitment as one of our greatest challenges, and expect that with increased online job site visibility and increased presence at job fairs targeted to recruit needed staff we will be able to successfully recruit more staff which will allow us to maintain the needed capacity to be able to offer access to ICC services within three days of family consent.

In addition, the proposal includes the development of a computer based orientation program which we believe will help streamline the on-boarding of new hires and will help ensure consistency in the initial training across all sites at CHL and LUK.

We also are aware, based on the demographics of our communities, that it is essential to have an increased capacity to serve individuals whose primary language is not English. We are, therefore, planning to target Spanish speaking staff through collaborations with CENTRO and Spanish American Center. Recruitment materials will be available in Spanish for those community agencies to distribute. In addition, all staff will have access to tablets and to our video translation service. We believe that this will more easily engage families in the CSA process than our previous telephone translation service.

E. Connections to social services

One of CHL and LUK's strengths is in effectively connecting youth and families to community and social services. Staff are recruited from our service communities, they are orientated and updated about resources, they make personnel connections within the provider communities, they have experiences which they report back to the team and then use that information to assist in future connections. The team has a regularly reviewed an updated service directory. Staff receive emails from various coalitions which list upcoming events and new services. They will be trained to use the Aunt Bertha, Inc. platform which will be the Central Massachusetts Accountable Care Organization's information and referral system. Weekly team meetings include an agenda item to share any new resources or connections. New staff training includes visits to community agencies with seasoned staff to learn about the service and meet individuals at the agency.

We expect that the new EHR will improve our collaboration with social services. With the necessary releases in place, we will have the capacity to print Care Plans while in the community using our mobile technology as well as send them electronically to individuals on the Care Planning Teams

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CSA Budget Report

Community Healthlink, Inc.

Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites	3	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate	NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)	231	231	231	231	231	231	
Estimated Funds	$ 254,844.00	$ 161,700	$ 97,020	$ 69,300	$ 60,984	$ 27,720	**$ 671,568**
At- Risk Withhold Rate			5%	10%	15%	20%	
Withhold			$ 4,851	$ 6,930	$ 9,148	$ 5,544	**$ 26,473**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 254,844.00	$ 161,700	$ 92,169	$ 62,370	$ 51,836	$ 22,176	**$ 645,095.40**

Investment Projects	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Project 1 Name: *Development of Electronic Medical Record*							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ 112,835	$ 82,765	$ -	$ -	$ -	$ -	$ 195,600
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 1 Total	$ 112,835	$ 82,765	$ -	$ -	$ -	$ -	$ 195,600
Project 2 Name: *Inservice Training*							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ 4,000	$ 5,000	$ 5,000	$ 3,000	$ 2,000	$ 2,000	$ 21,000
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 2 Total	$ 4,000	$ 5,000	$ 5,000	$ 3,000	$ 2,000	$ 2,000	$ 21,000
Project 3 Name: *Purchase of Mobile Devices*							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ 90,000	$ 50,000	$ 73,300	$ 49,080	$ 41,000	$ 15,700	$ 319,080
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							

Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 3 Total		$ 90,000	$ 50,000	$ 73,300	$ 49,080	$ 41,000	$ 15,700	**$ 319,080**
Project 4 Name: *Recruitment*								
DSRIP Goal(s) Addressed:	Goal 1:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses		$ 11,500	$ 5,000	$ 3,000	$ 3,000	$ 2,720	$ 1,860	**$ 27,080**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 4 Total		$ 11,500	$ 5,000	$ 3,000	$ 3,000	$ 2,720	$ 1,860	**$ 27,080**
Project 5 Name: *Video Conferencing*								
DSRIP Goal(s) Addressed:	Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses		$ 6,000	$ -	$ -	$ -	$ -	$ -	**$ 6,000**
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 5 Total		$ 6,000	$ -	$ -	$ -	$ -	$ -	**$ 6,000**
Total Project Costs		$ 224,335	$ 142,765	$ 81,300	$ 55,080	$ 45,720	$ 19,560	**$ 568,760**
Indirect Costs/ Administrative Overhead Rate	13.6%	$ 30,509	$ 19,416	$ 11,057	$ 7,491	$ 6,218	$ 2,660	**$ 77,351**
Investment Projects Total		$ 254,844	$ 162,181	$ 92,357	$ 62,571	$ 51,938	$ 22,220	**$ 646,111**

CSA Budget Report - Budget Narrative Prep Budget Period

CSA Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name: Development of EHR
DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care planning, care*
2 *(1) Fostering strong integration with ACOs and primary care providers for ICC-Engage*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Electronic Health Record Project	$ 112,835
Total Development and Adaptation of EHR and Care Management System	$ 112,835

Electronic Health Record Project: will strengthen fidelity to Wraparound processes and will allow for more effective electronic communication and therefore increase integration with ACOs and PCPs. The goals are to have a system that:
ICC and Family Partners will use to document all aspects of their work with youth and families including all Assessments, Care Plans, and Transition Plans.
Assists staff to know when required processes and documents are due.
Allows supervisors to easily run regular reports to monitor compliance with required processes and documents.
Improves the quality of supervision of staff by allowing more efficient review of key elements of the record for quality.
Connects to the MA Hiway and communicates with ACOs and PCPs.
Produces reports the reflect quality measures and outcomes
If awarded the Community Partnership contract in Central MA we will receive DSRIP funds to assist in the development of Qualifacts CareLogic for the programs involved in the CP initiative. There is no overlap with the DSRIP funds we are requesting for the CP initiative. These are costs allocated to the CSAs for the development of CSA specific documents, reports and billing.

We have allocated $112,835 toward the development of the EHR for the CSAs during the Prep period. This allocation will assist all three CSAs. CSAs will utilize all the same Qualifacts forms which are being tailored to the CSAs' paperwork requirements. The $112,835 is the CSA's percentage of the initial start up cost of Qualifacts based on the CSA's percent in CHL's budget. We expect to have the EHR developed and staff trained by the end of the Pre Budget Period.

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Inservice Training
DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care planni*
2 *(1) Fostering strong integration with ACOs and primary care providers for ICC-*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name: Purchase of Mobile Devices
DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care planni*
2 *(3) Improving timely access to ICC services for children eligible to receive ICC*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Mobile Technology	$ 90,000.00
Total Technology for Service Delivery	$ 90,000.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:
Mobile Technology Project: This project will strengthen fidelity to the Wraparound processes and increase timely access to ICC services. The goals are:
To enable staff to access video translation services so as to enhance the quality of the family's experience when staff do not speak the family's preferred language.
To provide staff access to the new EHR in real time while in the community with youth and families so that families may take an increased role in their Care Planning process.
To enable staff access to the internet so as to complete Care Planning tasks with families in the community in real time.
We have allocated $90,000 for mobile devices including a combination of laptops and tablets, signature pads, cell phones and mobile printers for the staff of both LUK and CHL in all three CSAs. These devices will be able to connect with the EHR securely in the field and there will be tablets that can be used to connect to the video translation service.
The Laptops or Tablets and software for each of the CSA staff which includes signature pads or signature capability on the tablet at an average of $1400 per staff at $81,200. (Software has not been ordered. A current price of HP laptop and software is $1300 and the signature pads are $100. The Ipad are similar in cost and need a license for the mobile AP for the EHR.) We will order toward the end of the development of our EHR to make sure all devices are compatible with the record. There is a cost of $1736 for Lolack for these devices; software which tracks and prevent theft. We will purchase two portable printers per CSA site (two CHL; Two LUK) at a cost of approximately $2064. We propose to purchase 25 cell phones at approximately $200 each for an additional $5000.

North Central: currently 26 FTE. Projected for training 30.5 FTE
Worcester East: currently 16 FTE. Projected for training = 17 FTE

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name: Recruitment
DSRIP Project Goal(s):
1 *(3) Improving timely access to ICC services for children eligible to receive ICC*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name: Video Conferencing
DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care planni*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Video conferencing equipment	$ 6,000.00
Total Other Technology Expenses	$ 6,000.00

Video Conferencing Project: will increase communication and lead to greater efficiency of our leadership and thus strengthen fidelity to the model. The goal is to:
Develop the capacity for all CHL/LUK CSA supervisors to efficiently "virtually meet" on a regular basis to share best practices, discuss quality initiatives, and develop greater consistency with respect to performance expectations.
To achieve this goal, we are proposing to purchase 4 Polycom portable monitor, camera and computer units at $1500 a unit. We will install one at 99 Day Street and 545 Westminster St. for LUK staff and management and one at 100 Erdman Way and one at 199 Chandler St. for CHL sites. The total cost of this initiative is $6000 and it will be completed within the Prep Budget Period.

CSA Budget Report - Workforce Development - Prep Budget Period

Project 1 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Inservice training	$ 4,000.00
Total Training Expenses	$ 4,000.00

Training project will strengthen fidelity to the Wraparound processes and assist in the integration with ACOs and primary care providers for ICC-Engaged youth and their families. The goals are to:
To obtain outside consultation and in-service training around specific topics pertaining to work with special populations and coordination with pediatric primary care.
In the Prep Budget we have allocated $4000 for the outside consultation and trainings. The plan is to have the CSA staff and managers plan annually for the training based on the needs of the programs and the recommendations of the Development Plans over the five years.

All staff in all 3 CSAs including the two LUK subcontracted sites will benefit from this training. The details of the specific trainings we will provide are being developed. We expect the trainers - since many will be medical professionals - to charge approximately $200/hour based on our initial overtures to potential trainers. This $4000 will provide approximately 20 hours of training from outside consultants. Our expectation is that all staff from all sites - both Family Partner staff and Care Coordinators - will receive training.

North Central: currently 26 FTE. Projected for training 30.5 FTE
Worcester East: currently 16 FTE. Projected for training = 17 FTE
Worcester West: currently 16 FTE. Projected for training = 20.5 FTE

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Online recruitment enhancements	$ 8,000.00
Develop recruitment materials	$ 1,500.00
Job Fair expenditures	$ 2,000.00
Total Recruitment Expenses	$ 11,500.00

In the Prep Budget we have allocated $8000 for costs related to advertising on Monster.com and to have ads prioritized on Indeed.com for both CHL and LUK. The estimated cost for increasing our advertising is $800/per month per agency (LUK and CHL). We plan to enhanse the ads for 5 months to attract staff - particularly bilingual staff.

We have $1500 for the development of recruitment materials to be used at Job Fairs and to have the material translated into Spanish. $2000 is allocated for Job Fair expenses including space and refreshments. We plan to hold two Job Fairs for the CSAs during the prep period one in Worcester and one in NC.

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 1 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 1 Name:	Development of EHR	**Project 2 Name:**	Inservice Training	**Project 3 Name:**	Purchase of Mobile Devices	**Project 4 Name:**	Recruitment	**Project 5 Name:**	Video Conferencing
DSRIP Project Goal(s):	**1** *(2) Strengthening fidelity to Wraparound processes, including the care planning, care*	**DSRIP Project Goal(s):**	**1** *(2) Strengthening fidelity to Wraparound processes, including the care planni*	**DSRIP Project Goal(s):**	**1** *(2) Strengthening fidelity to Wraparound processes, including the care planni*	**DSRIP Project Goal(s):**	**1** *(3) Improving timely access to ICC services for children eligible to receive ICC*	**DSRIP Project Goal(s):**	**1** *(2) Strengthening fidelity to Wraparound processes, including the care planni*
	2 *(1) Fostering strong integration with ACOs and primary care providers for ICC-Engage*		**2** *(1) Fostering strong integration with ACOs and primary care providers for ICC-*		**2** *(3) Improving timely access to ICC services for children eligible to receive ICC*		**2** *Optional*		**2** *Optional*
	3 *Optional*		**3** *Optional*		**3** *Optional*		**3** *Optional*		**3** *Optional*

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate: **77.351**

Provide a brief description of how the Indirect Cost/Administrative Overhead rate was determined:

Community Healthlink's Federally Apporved Indirect Cost Rate is 13.6%.

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS March 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
1	Electronic Health Record	Implement an Electronic Health Record that will be used to document all aspects of ICC and FS&T work	07/01/17	12/31/18	**Technology**	Development Adaptation of EHR and/or Care Management System	100% of staff, including supervisors and administrators, from all 3 CSAs (including subcontracted staff) will be trained in the use of the new Electronic Health Record	Percentage of Staff completeting training			100% of all CSA Staff will be using the new Electronic Health Record (system will be fully implemented)	Percentage of staff using the new Electronic Health Record		
2	Staff Training	Create and implement a schedule of special topic trainings to include increasing skill level around working with Primary Care professionals and conducting wraparound with special populations.	01/01/18	12/31/22	**Workforce Development**	Training Expenses	Development of the 2018 training calendar for direct care staff and supervisors detailing topics for the 2018 calendar year	Calendar is created with specfic dates/times and topics for the 2018 calendar year.			At least 2 trainings will have occurred	85% of staff will have attended at least 2 trainigns		
3	Mobile Technologies	1. staff will increase use of mobile devices in the commuity with enrolled families	07/01/18	06/30/19	**Technology**	Technology for Service Delivery	The CSA program will have determined which type of mobile device will work best for FCT staff (i.e. laptop vs tablets; which operating system, what will work best with the new electronic record,etc.)	Ordering of mobile devices for FCT staff.			At least 50% of staff will be using mobile devices in the field with enrolled families	Percentage of staff using mobile devices on a regular basis		
3	Mobile Technologies	2. staff will have access to video translation services;	07/01/18	12/31/18	**Technology**	Technology for Service Delivery	The CSA program will have identified a provider for the video translation service	Vendor has been identified			At least 50% of CSA staff will have been trained to use the Video Translation service.	Equipment will have been purchased. Percentage of staff completeting training		
4	Rcruitment	Each CSA will increase the number of bi-lingual and bi-cultural staff by 10%	01/01/18	12/31/22	**Workforce Development**	Recruitment Expenses	The CSA will have produced new recruitment materials in Spanish and English describing the jobs available in the CSA.	Recruitment materials available in Spanish						
					Workforce Development	Recruitment Expenses	The CSA will have proiority postings on INDEED and MONSTER websites	The CSA will have proiority postings on INDEED and MONSTER websites						
					Workforce Development	Training Expenses	Job Fairs will have been scheduled	Date, Location, and Time for Job Fair will be established			Increased number of applications for CSA jobs especially for bi-lingual bi-cultural candidates	Both job fairs will have occurred		
5	Video Conferencing Project	All senior staff from every CHL CSA site will be able to meet together via video conferencing.	01/01/18	12/31/18	**Operational Infrastructure**	Other Operational Expenses	Video Conferencing equipment will be purchased and installed in each CSA site	All senior CSA staff will have held at least 1 meeting via video conferencing			CSA Senior staff will have a regular schedule of meeting across all sites via the video conferencing equipment	Regular meeting of CSA senior staff (at least monthly)		
					Operational Infrastructure	Operation Staffing including Fringe								
					Operational Infrastructure	Other Operational Expenses								
					Operational Infrastructure									
					Operational Infrastructure									

Implementation Preparation Budget Period
Plan and Timeline

The activities related to the five (5) Community Healthlink's Projects are colored coded in the chart below.

Electronic Health Record
Staff Training
Mobile Technology
Recruitment
Video Conferencing
Activities related to all 5 projects

Action /Task	Timeframe	Individuals or teams assigned task
Meetings with LUK Leadership to review implementation plans and scheduling	**November and December 2017**	CHL and LUK leadership
Readiness review by EOHHS		CHL Leadership and EOHHS
Funding Begins		EOHHS
Meetings with Qualifacts to map out CSA work flow	**December**	Irsfeld, Droser, CSA Management, CSA front desk staff; IT managers, Qualifacts
Meetings with Qualifacts to set-up forms		Irsfeld, CSA Management, IT managers, Qualifacts
HR to contact Indeed.com and Monster.com to enhance advertisements	**January**	**Lavin, Hall**
Review job descriptions and qualifications for distribution at recruitment fair		**Irsfeld , CSA Managers, Lavin**
Set date and location for recruitment fair		**Popp, CSA Managers**
Video-conferencing equipment is ordered		**Rezkalla**
Meeting with Qualifacts to set-up Quality Measures		Irsfeld, Droser, CSA Management, IT managers, Qualifacts
Meeting with Qualifacts to set-up Reports		Irsfeld, Droser, CSA Management, IT managers, Qualifacts
Meetings with Qualifacts and CHL finance regarding billing procedures for CSA		Lito, Droser, Irsfeld, IT Managers, Qualifacts
Meet with CSA staff to gather information on training needs related to working with special populations and improving communication and interface with PCCs		**CSA leadership**
Job Fair materials translated into Spanish and materials readied for community distribution – layout and graphics	**February**	**Loy**
Hold recruitment fair in NC		**Irsfeld, Popp, CSA Managers**
Video-conferencing equipment is installed		**IT staff and CSA Managers**

in the 4 sites and managers are trained		
Managers schedule first meeting utilizing video conferencing equipment		**Irsfeld, CSA Managers**
Follow-up meeting with Qualifacts to review progress		Rezkalla, Irsfeld, Droser, Durr, IT Managers, Qualifacts
Test CSA components of Qualifacts with Managers and billing department		Lito, Irsfeld, Droser, IT Managers, Qualifacts
Meet with CSA Leadership to come up with list for in-service training **Finalize 2018 in-services; Contact trainers, set dates**		**CSA Leadership with Irsfeld**
Update, refresh Ads based on response and feedback	**March**	**HR Director**
Managers schedule first meeting utilizing video conferencing equipment		**Irsfeld, CSA Managers**
New Monster Ads are running and Indeed Ads are prioritized. HR and CSA receiving resumes and proceeding with hiring process		**Popp, Hall and CSA Managers**
Follow-up meeting with Qualifacts to review test		Rezkalla, Irsfeld, Droser, Durr, IT Managers, Qualifacts
Qualifacts to make adjustments based on test		Lito, Irsfeld, Droser, IT Managers, Qualifacts
Data is imported from previous EHR into Qualifacts		IT managers, Qualifacts
Staff are trained in using Qualifacts		Qualifacts, Irsfeld, IT Managers
IT and purchasing staff to solidify plan on Equipment purchase		IT, Managers
Hold recruitment fair in Worcester	**April**	**Irsfeld, Popp, CSA Managers**
Update, refresh Ads based on response and feedback		**Lavin**
Mobile Equipment purchases		**Rezkalla, IT managers, Hall**
All staff utilizing the new EHR on mobile devices.		Qualifacts, Irsfeld, IT Managers
Hold in-service training		**Irsfeld, CSA managers**
Create online Recruitment plan for Budget Period 1 based on results from Preparation Period.	**May**	**Lavin, Popp, Droser, Irsfeld**
Staff to receive mobile technology and receive training; All staff utilizing the new EHR on mobile devices.		**IT, Managers, Qualifacts**
Hold in-service training		**Irsfeld, CSA managers**

Implementation Plan and Timeline

Preparation Budget Period 1

The activities related to the five (5) Community Healthlink's Projects are colored coded in the chart below.

Electronic Health Record
Staff Training
Mobile Technology
Recruitment
Video Conferencing
Activities related to all 5 projects

Action /Task	Timeframe	Individuals or teams assigned task
	June 2018	
First Report due to EOHHS (within 60 days of the end of budget period)		Irsfeld, Droser
Qualifacts to review use of EHR make adjustments in flow, forms and reports as needed		Rezkalla, IT Managers, Qualifacts, Droser, Irsfeld, CSA Managers
Implement Online recruitment plan		**Lavin, Popp**
In-Service Training is held		Irsfeld, CSA Managers
	July- September	
Semi Annual Report due to EOHHS		Irsfeld, Droser
Submit requests for online recruitment enhancements based on feedback from Preparation period		**Lavin, Popp**
Fall Job Fair in Worcester		**Popp, CSA Managers**
	October – December	
Qualifacts to work with CSAs on reports and connections with other EHRs		Rezkalla, IT Managers, Irsfeld, Droser
In-service Training is held		**Irsfeld, CSA Managers**

Implementation Plan and Timeline

Budget Period 2

The activities related to the five (5) Community Healthlink's Projects are colored coded in the chart below.

Electronic Health Record
Staff Training
Mobile Technology
Recruitment
Video Conferencing
Activities related to all 5 projects

Action /Task	Timeframe	Individuals or teams assigned task
	January-March 2019	
Annual Report due to EOHHS (within 60 days of the end of budget period)		Droser, Irsfeld
CSA Staff and Managers create annual training plan		**Irsfeld, CSA Managers**
In-service Training is held		**Irsfeld, CSA Managers**
Feedback from Orientation is analyzed and edits put in place		**Irsfeld**
Purchase additional Mobile Technology for expanded staff if necessary		**IT Managers, Rezkalla**
Create online plan for the year based on staffing needs and feedback from previous year		**Popp, Lavin**
Hold Spring Job fair aimed at college and graduate school graduates		**Popp, CSA Managers**
	April-June	
In-service Training is held		**Irsfeld, CSA Managers**
	July- September	
Semi- Annual Report due		Droser, Irsfeld
In-service Training is held		**Irsfeld, CSA Managers**
	October – December	
In-service Training is held		**Irsfeld, CSA Managers**

Implementation Plan and Timeline

The activities related to the five (5) Community Healthlink's Projects are colored coded in the chart below.

Preparation Budget Period 3

Electronic Health Record
Staff Training
Mobile Technology
Recruitment
Video Conferencing
Activities related to all 5 projects

Action /Task	Timeframe	Individuals or teams assigned task
	January-March 2020	
Annual Report due to EOHHS (within 60 days of the end of budget period)		Droser, Irsfeld
CSA Staff and Managers create annual training plan		**Irsfeld, CSA Managers**
Create online plan for the year based on staffing needs and feedback from previous year		**Popp, Lavin**
Hold Spring Job fair aimed at college and graduate school graduates		**Popp, CSA Managers**
In-service Training is held		**Irsfeld, CSA Managers**
	April-June	
In-service Training is held		**Irsfeld, CSA Managers**
Purchase additional Mobile Technology for expanded staff if necessary		**IT Managers, Rezkalla**
	July- September	
Semi- Annual Report due		Droser, Irsfeld
In-service Training is held		**Irsfeld, CSA Managers**
	October – December	
In-service Training is held		**Irsfeld, CSA Managers**

Implementation Plan and Timeline

Preparation Budget Period 4

The activities related to the five (5) Community Healthlink's Projects are colored coded in the chart below.

Electronic Health Record
Staff Training
Mobile Technology
Recruitment
Video Conferencing
Activities related to all 5 projects

Action /Task	Timeframe	Individuals or teams assigned task
	January-March 2021	
Annual Report due to EOHHS (within 60 days of the end of budget period)		Droser, Irsfeld
In-service Training is held		**Irsfeld, CSA Managers**
Staff continue to utilize mobile technology in the field		**CSA Staff and Managers**
Create online plan for the year based on staffing needs and feedback from previous year		**Popp, Lavin**
Hold Spring Job fair aimed at college and graduate school graduates		**Popp, CSA Managers**
	April-June	
In-service Training is held		**Irsfeld, CSA Managers**
	July- September	
Semi- Annual Report due		Droser, Irsfeld
In-service Training is held		**Irsfeld, CSA Managers**
	October – December	
In-service Training is held		**Irsfeld, CSA Managers**

Implementation Plan and Timeline

The activities related to the five (5) Community Healthlink's Projects are colored coded in the chart below.

Preparation Budget Period 5

Electronic Health Record
Staff Training
Mobile Technology
Recruitment
Video Conferencing
Activities related to all 5 projects

Action /Task	Timeframe	Individuals or teams assigned task
	January-March 2022	
Annual Report due to EOHHS (within 60 days of the end of budget period)		Droser, Irsfeld
Staff continue to utilize mobile technology in the field		**CSA Staff and Managers**
Create online plan for the year based on staffing needs and feedback from previous year		**Popp, Lavin**
Hold Spring Job fair aimed at college and graduate school graduates		**Popp, CSA Managers**
In-service Training is held		**Irsfeld, CSA Managers**
	April-June	
In-service Training is held		**Irsfeld, CSA Managers**
	July- September	
Semi- Annual Report due		Droser, Irsfeld
In-service Training is held		**Irsfeld, CSA Managers**
	October – December	
In-service Training is held		**Irsfeld, CSA Managers**

CSA Budget Report			
Revision Requested	**CSA Budget Report Line**	**Description of Revision**	**Comments**
N/A	Estimated Funds	Original budget only summed BP 1-5, missing the PBP. As a fix, I adjusted Column I, line 8, to make sure it includes the PBP: It should read =SUM(C8:H8) in yellow highlight for review	
N/A	Indirect Costs	Changed cell formatting to allow for two decimal places	
Please Review	Investments project total	This value cannot be greater than the total maximum funds available per C11 calculation. Please adjust.	Adjusted cost of Credible integration to $73312

CSA Budget Narrative			
Revision Requested	**CSA Budget Narrative Line**	**Description of Revision**	**Comments**
Complete	Workforce Development: Project 1 Name	Incomplete, please include name	Project removed
Complete	Workforce Development: Project 1 Staffing Narrative	Explain what types of training activities will be prioritized under ICC Director/Trainer	Project removed
Complete	Workforce Development: Project 1 Staffing Narrative	DSRIP funding cannot be used as salary replacement; Please remove or explain how this is not salary replacement	Project removed
Complete	Workforce Development: Project 1 Training Expenses	Explain assumptions behind expected costs; in narrative explain how costs were calculated (i.e. expected costs per FTE, identify expected quantities of materials)	Project removed
Complete	Technology: Project 2 Technology for Service Delivery	Explain calculation used to determine total costs of expenses/ write out calculation that resulted in costs for each expense (i.e. 15 FTE x $600 cost of 2 in 1 laptops)	

Milestones			
Form Completed?	**Milestone**	**Description of Revision**	**Comments**
Y	Project 1 (H5)	Update according to revised budget; include how baseline for staff will be measured	

DSRIP Non Duplication Form			
Form Completed?	**Revision Requested**	**Description of Revision**	**Comments**
Y	N/A		

Participation Plan			
Final Submitted	**Revision Requested**	**Revision Requested**	**Comments**
Y	Please Review	Need to update to reflect removal of Workforce Development Project	

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6.1 INSTRUCTIONS FOR SUBMITTING THE PROGRAMMATIC RESPONSE
A. Goals

RFR Goals	CSA Development Plan Goal	DSRIP Project Activities
Improving timely access to ICC services for children eligible to receive ICC and their families.	Increase referrals to Family Support and Training (family partner services)	Outreach by Sr. Family Partner; Staff Training
Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC participants	Increase Family Voice and choice and use of natural supports	Staff Training; Technological Innovation (PCP integration)
Fostering strong integration with ACOs and primary care providers for ICC participants.	Increase attendance of community members at Care Plan meetings	Technological Innovation; Outreach by Sr. Family Partner CANS Integration with EHR and CCD transmission of information to PCP practices; Use of smart boards to support PCP remote participation in Care Plan Team meetings
Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC participants.	Improve quality of Comprehensive Assessment Wraparound certification for CSA staff	Staff Training; Technological Innovation

B. CSO DSRIP Projects:

CSO CSA Sites and Locations: Hampshire/Franklin/North Quabbin Area
Hampshire: 8 Atwood Drive, Northampton, MA 01060
Franklin: 1 Arch Place, Greenfield, MA 01013
North Quabbin: 491 Main Street, Athol, MA 01331

CSO has focused this last year on planning to build crucial infrastructure that will support CSA functions and responsibilities. CSO has positioned itself to take advantage of DSRIP funding opportunities to prioritize infrastructure building over initiatives with a short-term payoff. A strong and nimble human resources department has a plan to initiate cross-program staffing and cross training. Our Business Team has supported major technology advances to weave them into current operations. CSO priority goals for the CSA program and DSRIP projects that address them are as follows:

<u>Workforce Development – Training, Recruitment, Retention</u>

- Training/Tier 1 Wraparound Certification for Care Coordination. This will enhance adherence to model and will support connections to PCPs. This will also improve staff retention.
- ~~Recruitment: enhanced posting on Indeed.com, which significantly increases the number of "hits" and resumes/applicants for job openings; targeting Masters level Care Coordinators~~

~~Operational Infrastructure - Outreach~~

- ~~0.25 FTE of CSA's Senior Family Partner to do community outreach and education~~

Technology Innovations:

- Purchase/Upgrade of laptops for CSA staff
- ~~Purchase/upgrade of PCs for CSA staff~~
- ~~Smart phones with data plan for Care Coordinators~~
- Smart boards to support Care Planning team meetings and participation by PCP's
- Training materials for Tier 1 wraparound certification/manuals
- Projectors/roller cases to support mobile/community based care planning
- Upgrades to EHR (Credible) to include Credible Connect and integration of CANS directly with Credible, improving ability to track and share client outcomes and CCD data points with PCP's.

6.2 EXECUTIVE SUMMARY

A. The Bidder's current performance on its Development Plan

From the latest update of our CSA development Plan (April 2017), accomplishments include the following:

- All 3 sites have increased ICC referrals
- All ICC staff have attended or are scheduled to attend the 4 modules of the ARC orientation.
- All 3 sites hosted the Family Voice Forums,
- STAY Grant will be ending June 30th and the 2 Peer Mentors will continue to provide TM and Peer Mentor support.
- All 3 sites are in the process of hiring; we are hiring for a new Senior Partner

Strategies for Improvement: The following initiatives are being undertaken over the next six months to a year:

- Data indicates families could be more connected to community and youth need higher attendance at CPT meetings. During weekly supervision, supervisors will discuss and review team attendance and natural supports on the CPT and attendance sheets.
- Meeting with staff reviewing the goals and WEPA data and set goals
- Group supervision focusing on Community /Natural Supports topics
- Marketing to community and hubs for FS&T service to increase referral.
- Meet with local schools and DCF; DCF Supervisor planning meeting: ensure an increase in referrals; Triage/Referral Team meeting
- Presentation at all Staff Site meetings
- Start using ecomap/genogram
- Remind parents they can choose which meetings to have their supports attend.
- Natural supports can call in to the meetings, offer transportation, flexible times.
- Offer parents to invite natural supports to meetings other then Care Plan meetings.
- Meet with our EHR team to create the chosen action plan for FS&T - Action Plan will be created in EHR

B. Specific examples of strengths and needs of the Bidder;

Strengths: We serve over 2,000 youth with SED in our Outpatient programs at CSO, and have provide CBHI services to over 1,025 youth in the region and MCI/ESP services for more than 1,020 youth and their families. We have clinicians, psychologists, child certified NP's and board certified child psychiatrists with broad background and extensive experience with these youth, who both treat and may be called upon for consultation. Our core competencies lend themselves to the development of a "one-stop" wraparound model of comprehensive, holistic services to families with multiple and complex issues. CSO provides

Outpatient mental health and substance abuse treatment; school based consultation and treatment; case management; child and adult psychiatry; psychological testing and assessment; advocacy; parent skills training; a full range of Children's Behavioral Health (CBHI) programming; Intensive Care Coordination for youth and Community Support Program for youth and adults; Wellness programming; and crisis prevention planning, assessment and intervention for children, youth and adults. CSO has a well-developed Peer Services component, including Peers within our Crisis programs and Family partners at our Crisis services, CSA, and Family Resource Centers. Our status as the Emergency Services Provider throughout the Hampshire and Franklin/North Quabbin region means that we have the capacity for child and youth mobile crisis response. CSO has a current 4-year certification from the Council on Accreditation.

Training capacity: CSO has robust training capacity, which has been a key factor in our ability to offer region-wide Youth Mental Health First Aid under the federal "Now is the Time" program and Integrated Health Treatment Education and Training through a Commonwealth Corporation Workforce grant. Other training activities at CSO include a monthly Child Clinical Seminar Series, which focuses on developmental and trauma-related topics. We operate the SAMHSA-funded Trauma Training and Treatment Institute, which can lead to CSO certification in basic or advanced practice Trauma Informed Care. A multi-disciplinary steering committee ensures that ongoing training and quality supervision is available to all program staff. CSO's CSA Director, Mary-Jo Crowley, is a certified trainer and coach in Wraparound.

Sophisticated EHR: Credible Behavioral Health is CSO's electronic health record (EHR). It supports all statutory and regulatory requirements and is used for collecting, recording, storing and maintaining all data (live and historical) including client demographic information and insurance status. Credible enables engagement with external providers, past BH and medical records, comprehensive assessments and person-centered Care Plans and service delivery. It allows for collaboration with external providers to create an integrated care model and provides an Individualized Action Planning Module that allows for care planning and documentation. It is a fully configurable reporting tool to create custom reports, custom dashboards, and graphical reporting functionality for distribution. used for collecting and maintaining all data; Provider Portal, Client Portal, Direct Messaging, Summary of Care, eFax, collaboration with external providers to support consumers in navigating BAH system of care; and with appropriate releases, allows direct exchange of data and forms within the portal.

Needs: We experience a high level of severity and intensity of the mental, emotional, and behavioral problems of children and youth who are referred to the CSA program. One outcome of this intensity is that we experience difficulties in recruitment and retention of CSA staff. Staff have requested certification in Tier 1 Wraparound as a way to enhance their abilities and improve their confidence delivering services to this population. Training and support, and assuring the time available to train staff, is a critical need for this program.

In terms of service delivery, we believe that treatment must be accessible across the spectrum of CSO clinical services and that a very close collaboration with others (agencies, school and individual practitioners) who treat the child or youth is critical.

C. The Bidder's plans for improving timely access to ICC services

Improvement of timeliness of access to ICC services will focus on two aspects of services delivery: 1) enhancement of the ease of referral to CBHI services by other providers, and 2)

increased knowledge of the service, especially by pediatricians ~~and intensified outreach by a Senior Family Partner.~~ Plans are detailed in subsequent sections.

D. The Bidder's plans for improving care coordination, care planning, and care management for ICC-Engaged Members

C*SO's service goal* is to effect greater collaboration and coordination across the spectrum of healthcare providers—inpatient medical and BH, primary and specialty medical, outpatient and community-based BH, residential, LTSS and emergency care. *CSO's operational goal* is to implement the CSA program efficiently, expeditiously, and sustainably. We will approach enhancement of operations with a clear plan and model, with the flexibility and agility to adapt our plans and process in response to changing conditions, consumer feedback, and feedback from ACOs, MCOs and our healthcare partners. Our broader plans are to:

- Enhance centralized electronic files/electronic medical records with ready, universal access by staff.
- Encourage parent/guardian access to youth records, Care Plans, service delivery and communication through the client portal of Credible.
- Orient other providers/partnering health care organizations to Credible Provider Portal.
- Enable electronic data sharing of CCD data points, and outcome measures related to CANS data, between CSA and Primary Care providers.
- Train staff in use of Care Plan/Comprehensive Assessment module and processes, Integrated Health Management, evidence based practice
- Use of smart-board technology in Care Plan Team meetings to enable mobile care plan meetings and virtual participation by members who are unable to physically attend the meeting in the same location.

E. Plans to improve performance on quality scores and Development Plan goals

Goals that are part of our CSA Development Plan are to:

- Increase referrals to Family Support and Training (family partner services)
- Increase Family Voice and choice and use of natural supports
- Increase attendance of community members at Care Plan meetings
- Improve quality of Comprehensive Assessment

The current priority for action in the CSO Development Plan is to improve our Comprehensive Assessment process, in order to improve ready access to ICC services. One aspect of addressing this priority is staff training and better recruitment, leading to better retention. This will result in highly qualified staff conducting timely and comprehensive assessments in collaborative planning processes. Technological support funded by DSRIP funds will improve the quality of the Comprehensive Assessment. ~~Senior Family Partner Outreach will result in increased referrals as well as identifying greater opportunities for family partner recruitment.~~

F. Plans for improving coordination with pediatric PCPs & other care providers

CSO is the convener or participating member of five county-level System of Care Committees in Franklin, North Quabbin, Hampshire, and Berkshire Counties and the city of Springfield. Members include all major child-serving organizations for each catchment area. CSO sees a high volume of referrals from private practices, pediatricians' offices and other health organizations. We have referral relationships with 86 physicians in Greenfield, Northampton, Turner's Fall, and South Deerfield. North Quabbin Family Physicians, West River Health Clinic and Athol Memorial PCPs are all primary care resources with whom we have close working relationships and systems of mutual referrals in the North Quabbin area. We also have close working relationship with Baystate Primary Care practices; Valley Medical Practices; and the Cooley-Dickinson Primary Care practices. Orientation and

training for primary care staff to use of the Credible provider portal will allow electronic exchange of client information. Outreach by the Senior Family Partner will fortify CCS relationship with pediatric practices.

In addition, CSO has a training and certification program, Integrated Health Management, to train CSO staff to integrate health concerns with behavioral health planning. The program supports staff in working with primary care providers, including pediatricians. The further integration of the CSA program will be enhanced through cross training and sharing of staff using the following strategies: 1) Integrate CBHI services including ICC, family partners, peer mentors, behavior management, in-home behavioral therapy, behavior monitoring with additional Wraparound programming and evidence-based practices. 2) Strengthen the collaborations that already exist among OP, CBHI, CSP and Crisis to increase fluidity of staffing, flexible programming and economies of scale to support families.

6.3 POPULATIONS SERVED AND COMMUNITY ENGAGEMENT

A. Member populations and communities, the regions or service areas covered; plans to promote the health and wellbeing of the individuals it serves & maintain engagement

Geography and Demographics: Residents in CSO's identified service areas for the CSA program—Franklin and Hampshire Counties and the North Quabbin region—are predominantly Caucasian and English-speaking. The demographics of the Franklin-North Quabbin service area are 98% white, 0.8% African American, 0.6% Asian, and 1.7% Hispanic. In over 95% of households, English is the first language. Hampshire County demographics are 91.10% White, 1.96% Black or African American and 3.40% Asian; 3.42% of the population were Hispanic of any race. Made up of these service areas, this is a rural region: Hampshire is 80% rural and Franklin County and North Quabbin/northwestern Worcester County are 96.3% rural.

The rural population of focus for the project is a historically underserved population from a behavioral health care perspective. In general, the situation can be attributed to three converging regional characteristics: low socioeconomic status reflecting low education levels and the lack of quality employment; low health literacy; and limited access to treatment and support, reflecting the economics and rural geography of the area. Many residents of the service area have a lack of knowledge about available resources, are not well-informed about benefits they are eligible for and experience physical and psychological barriers to obtaining health care. Breakdown of access within the service system, inappropriate use of the emergency room and unnecessary hospitalizations are major costs in places with a lack of access to less restrictive, less expensive and more effective community services. CSO has developed expertise in working with the rural population, with a keen understanding of unique needs of individuals and families in the rural tri-county area, and a vested role in providing coordination of health, behavioral health and social services systems.

Stigma is particularly intense in rural communities, where anonymity is difficult to maintain.[1] The negative attitudes attached to having a mental disorder in a rural area can lead to under-diagnosis and under-treatment of mental disorders among rural residents. At CSO we believe that addressing the stigmatization of people with behavioral health challenges is one of our most important responsibilities.

Engagement: The foundation of family engagement is the development of relationships with our families. Building relationships between families and staff requires a well-trained and prepared workforce that can demonstrate and communicate respect and offer families trustworthiness. One aspect of the Family Team that its staff members must grapple with is

[1] Report of the President's New Freedom Commission on Mental Health

their accountability to the family, who is their client. This is "unconditional", according to wraparound principles, and involves evaluating and re-evaluating treatment modalities, making continual adjustments to the plan, and re-examining the goals of the plan and its definition of success, when necessary. Training funded by DSRIP will reinforce these strategies.

Health and Well Being: CSO's overarching goal is a system of care that fully integrates community outreach, wellness support and care coordination—and supports operational redesigns (e.g. maximum co-location of health and behavioral health, new care coordination protocols) to advance that goal. The purpose is to eliminate health disparities and the physical toll of preventable diseases in children and youth with SED and their families. CSO has maintained a long-term commitment to integrating wellness programming into our services. We want to employ any and all strategies in creating a seamless continuum of health promotion and wellness that increases the access and availability of prevention, outreach and treatment of the common conditions that prevent our mentally ill clients from attaining an optimal quality of life. This encompasses families of our child and youth clients. Wellness include coordination of community collaborations for wellness programming; wellness solutions specifically designed to enhance client health and well being; and integration of comprehensive wellness activities into behavioral health programs for clients, through education and outreach initiatives. Activities include yoga, acupuncture, mindfulness training, smoking cessation support, exercise equipment and classes, partnerships with local health providers for dental and health screenings, nutrition classes, walking classes and recreational activities and outings.

B. Describe relationships within the community to improve the quality of ICC services, including current and planned collaborations and partnerships

Local Schools: CSO has close working relationships with all the schools throughout Franklin County and the North Quabbin region. We are the subcontracted school-based clinical provider for the Athol Hospital CHART program, providing clinician's on site at three Athol schools; provide clinical consultation from our Child Psychiatrist via a telehealth grant to the Narragansett School District; and are leading a grant funded trauma informed school culture process with the Pioneer Valley Regional School District, Gill Montague Regional School District, and Mohawk Trail Regional School District. As the contracted Community Service Agency providing Intensive Care Coordination services, and the largest child outpatient behavioral health and CBHI provider in the Franklin/N. Quabbin region, we collaborate daily on identified cases and take referrals from all schools within our catchment area. Part of our Development Plan is to increase contacts with local schools to increase referrals and to further integrate services to children with school personnel.

Community Action: CA co-hosts Communities that Care (CTC) in Franklin County/North Quabbin with Partnership for Youth, a program of the Franklin Regional Council of Governments. CTC brings together youth, parents, schools, community agencies, and local governments to promote the health and well being of young people in Franklin County and the North Quabbin region. CTC is supported by the Regional School Health Task Force, composed of representatives from nine school districts: Athol/Royalston, Four Rivers Public Charter School, Franklin County Technical School, Frontier, Gill-Montague, Greenfield, Mohawk Trail, and Pioneer Valley, and Ralph C. Mahar Middle/High Schools. We will work closely with CA and CTC to access available resources for the TDS program.

WMTC: Western Mass. Training Consortium and the Recovery Learning Community runs on-line discussions and an announcement/bulletin board page. The Consortium also houses

the Western Mass. chapter of the Parent/Professional Advocacy League (PAL). These organizations have many strong advocates for community-based services.

Baystate Medical Center Partial Hospital Program (for adults and children): Regular meetings and primary referral source for aftercare planning and step-down services.

Brattleboro Retreat: CSO was instrumental on development of BR as a badly needed resource for MassHealth children in the region; we have regular meetings with BR Central Intake.

Cutchins Programs for Children & Families: residential, outpatient, and special education services provide children and families struggling with the effects of trauma and mental illness.

The North Quabbin Community Coalition is a community-wide alliance committed to improving the quality of life for all those living and working in the North Quabbin (Franklin and northern Worcester Counties) region. NQCC partners with local schools to identify resources to support programs, and offers the Enough Abuse campaign to end child abuse in the region.

Northampton Pediatrics, Athol Memorial/Heywood Physician Group, Valley Medical and Baystate Franklin Pediatric Practices: CSO is developing enhanced relationships with key primary care practices utilizing consultation with our Child Psychiatrists and planned outreach by a Sr. Family Partner to ensure knowledge of CSA services. Outreach and collaboration will improve access to services including streamlined referrals and knowledge of CSA services; and participation in Care Plan team meetings and sharing of information.

CSO staff will also identify the appropriate community providers and school personnel to be involved with the youth and family throughout the assessment and care planning process.

C. Describe how the current and planned partnerships described in response to Section 6.3.B align with the Bidder's proposed project(s) described in response to Section 6.4.A.

The purpose of enhanced and strengthened partnerships is to increase referrals and provide ready access to CSA services. It is also intended to strengthen the wraparound process. CSO's wraparound vision combines the development of family strengths and resources while maximizing the resources of CSO and the community. We have specific procedures for communication between levels of care, implementation of crisis plans, emergency psychopharmacology, and access to information across programs utilizing electronic medical records, voicemail and fax. Our partners, too, have extensive experience in wraparound; we share a common perspective and underlying philosophy about service delivery.

Developmental, social, educational and vocational needs will be addressed collaboratively. Youth expertise from the community is incorporated into the Comprehensive Assessment using programs such as CBFS-TAY, Dial-Self, YMCA, and the youth programs at the Clubhouses for youth and with schools, after-school and other programming for children. Families will be encouraged to include other providers, natural supports, and school staff on treatment team reviews and planning meetings. CSA staff will strengthen communication with community providers by ensuring that regular contact with these identified community providers and school feedback is initiated.

In addition to reaching out to families the Senior Family Partner will make contact with providers (e.g. pediatricians) and community organizations who have not yet been part of our Systems of Care groups and will offer orientation to CSO's CSA programming. Providers will be oriented to and trained in using the Credible Provider portal to share specific health record information, which will include consent and HIPAA protocols. Additional training on

Comprehensive Assessment will be provided, including Tier 1 Certification in the Wraparound process. This will enhance the Comprehensive Assessment planning process as well as the monitoring of Care Plan goals and child/family progress.

6.4 PROPOSED PROJECT(S) AND INVESTMENT PLAN

A. Project description

Project 1: Workforce Development: Upgrading the CSA Team : Tier 1 Wraparound Certification

The CSA workforce is comprised of graduate trained professionals, direct care staff with a BA degree or with on the job training and experience, and family partners who have parented a child with serious emotional disturbance.

Better leverage of the rural CSA core workforce will lead to more comprehensive, higher quality services including a higher level of health and behavioral health integration, more ready access to services and higher rates of recruitment and retention..

In order for CSO to move toward a more credentialed, licensed, and professional workforce, there must be enough professional development and advancement opportunities that incorporate core competencies and provide credibility to the field. In turn this helps us create well-defined career paths to support retention efforts by helping individuals progress into more senior and leadership positions. Staff most commonly need training in EBPs and behavioral management of clients, as well as certification in Wraparound.

To support clinical best practice and innovation, one of CSO's priorities is on developing an infrastructure to support staff in providing high fidelity evidence-based, best and promising practices. Our approach is to provide quality training that offers the opportunity to acquire and practice the skills necessary to successfully implement these practices. In addition, CSO has extensive training capacity, which has been a key factor in our ability to expand and enhance our ability to serve children and families.

CSO is eager to accelerate the collective learning curve in the enhancement of CSA. Our approach to staff training and professional development is key to transforming practice and programming in the agency. We will implement the broadest application of and access to training resources across the agency, deploying our capacity to reach across a large geographic area to train all CSA staff. We will identify specific opportunities and curricula for training staff to achieve Tier 1 Certification. Wraparound certification courses will be offered ~~as well as certification in Integrated Health Management.~~ We believe that better trained staff will have increased sense of mastery over position, and therefore stay longer in the job.

~~1. b. Operational Infrastructure: Targeted initiatives to increase referrals and ready access to CBHI services~~

~~Almost all CSA program staff are non-master's professionals delivering community-based outreach services across alls sectors of the community. The breadth of experience, views, skills, advocacy and values that paraprofessional staff bring to the table and share has led to an overall stronger treatment team and more responsive service delivery system within CSO.~~

~~We will allocate 25% of a Senior Family Partner's time to conduct and extensive outreach effort focused on current partners who serve families who are likely to need services for their children, as well as direct outreach to parents. The Sr. FP will also conduct intensive outreach to area pediatrician offices, targeting the PCP's to educate them on CSA services and the value of participation in the Care Planning team process. The FP will provide information, training, support, advocacy and related services. The point is to effectively represent and advocate in support of families.~~

Project 2: Technology Enhancement~~Support: Facilitating referrals, assessments and team communications~~

This project will provide new hardware and training support for an enhanced Comprehensive Assessment process and CANS integration and outcome reporting, along with CCD data transmission, that supports teams in conducting mobile and site based Care Planning Team assessments and improves participation and collaboration with Primary Care and ACO teams on ICC Care Plan teams. Training/orientation support will be offered to current and new partners in use of the Credible provider portal to share client information. Credible will be enhanced to fully integrate CANS into the EHR, including outcome reporting and CCD data transmission.

2. The specific goal, as defined in Section 3.4, advanced by the project and plans to address the goal through the proposed project

a. Workforce Development Goal: Broaden and deepen CSA staff skills to provide high quality services.

Our goal is to improve recruitment and retention of CSA staff by providing ongoing training (i.e., direct care staff, supervisors, management) and offering on-going licensing and credentialing opportunities for the CSA workforce especially in areas of measurement and data analysis, health behavior models, evidence-based practices, HIT, specific treatment modalities, and treatment plan development.

Skill Sets that new training curricula will address:

- The ability to conduct brief, evidence-based and developmentally appropriate screening and to conduct or arrange for more detailed assessments when indicated.
- The ability to create and implement integrated care plans, ensuring access to an array of linked services, and the exchange of information among consumers, family members, and providers.
- ~~The ability to deliver evidence-based, integrated approaches to the treatment of health conditions, adapting them to the population, treatment setting, and local system of care.~~

~~**b. Operational Infrastructure Goal**~~

~~The goal of the Senior Family Partner outreach is to effectively represent and advocate in support of families and to orient and educate all stakeholders, families and providers alike, to the CSA system. This will make services more readily available to those who need them, will increase referrals to the program and will provide greater recruitment of new Family Partners.~~

Project 2: Technology ~~Innovation~~ Enhancements Goal:

CSA will embrace HIT and support its implementation in order to survive in the more integrated healthcare system emerging through healthcare reform. Objectives are to:

- Through the care plans, link multiple services, healthcare providers, and community resources to meet the healthcare consumers' needs.
- Ensure the flow and exchange of information among the healthcare consumer, family members, and linked providers.
- Screen, assess and provide services to clients using computer-based and web-based tools.
- Employ telehealth applications to ensure consumer access to appropriate care and to deliver health care.
- Facilitate collaborative care by actively sharing relevant information with others through communications that are authorized by the healthcare consumer and are permissible under HIPAA and related laws, regulations and policies.
- Communicate with healthcare consumers and family members using secure online, mobile, and "smart" technology and devices.

3. The scope of the project, including duration of time during which the funds received under the Contract shall support the project, and the planned methods and activities that shall be performed to achieve the identified goal

Project 1: Tier 1 Certification:

a Workforce Development

Increase the hours of training offered to CSA staff. This entails allocating time of a Master Trainer to provide wrap certification training, and allocating time for Care Coordinators to achieve Tier 1 certification. The training program will span the five years of the grant, albeit at a diminishing level of training each year.

~~**b. Operational Infrastructure**~~

~~The outreach project will allocate 0.25 FTE of Senior Family Partner time for outreach in the Prep Period only.~~

Project 2: Technology Enhancement:

The predominant expenditure for this project will be enhancements to our electronic health record, Credible. We will purchase/implement Credible Connect to ensure ability to translate CCD data points, as well as build in CANS integration to improve outcomes reporting and sharing of CANS data with PCP's. ~~occur in through~~ CSO will also purchase hardware and adjunct equipment in the Prep Period as well as ongoing funding of software licenses and ongoing maintenance fees ~~and data plans~~ through Years 2-5.

4. Proposed deliverables that will result from the project

a. Workforce Development

The purpose of Wraparound certification to ensure caregivers and youth have access to the people and processes in which decisions are made as well as access to needed resources and services; to ensure family's voices are heard and they are full decision makers in charge of their own lives; and to ensure the family has ownership of the planning process in partnership with the team and is in agreement and committed to carry out the plan. Research has shown that consistent use of high fidelity wraparound processes leads to improved outcomes for children with complex needs and their families.

Certification courses provide a standard curriculum and training hours in core requirements. It is a multi-modal training with materials that can be flexibly provided for individuals, small groups or larger trainings. The training can be individualized to the learning styles of the staff and to the nuances of the population served.

As a follow-up, coaching will involve following front-line staff as they partner with families utilizing the wraparound practice model and moving through the phases of wraparound. Thus, coaching will focus on supporting all staff to move toward high-fidelity and quality wraparound practice during each phase.

~~CSO has implemented an innovative staff training program for all CSO staff. *Integrated Health Treatment Education and Training* (IHTET) is a program of education and training to develop general skills for mental health practitioners/professionals in engaging patients, promoting their self-efficacy to improve their own health, using general medical knowledge to be able to connect them to appropriate services, to address questions and to support client-directed integrated treatment planning that include physical health and wellness goals. BH DSRIP staff will be required to attend all of the IHTET modules, described below, as part of their orientation and ongoing training.~~

~~The training program enables CSO staff to (1) support people who are coping with chronic illnesses that put their health and/or social functioning at risk; and (2) use an integrated approach to addressing health problems and finding solutions. The course offers~~

~~certification at two levels: basic, for all CSO staff; and advanced practice, for those who have care coordination or care management responsibilities.~~

~~Through IHTET, CSO staff are trained to offer:~~

- ~~Development of hierarchy of client needs, physical and mental, to help clients to make a plan that they can follow through to address these needs;~~
- ~~Support for clients in "buying in" to their own self-care;~~
- ~~Help for clients to overcome fears concerning meds, procedures, surgeries, etc., helping them attain a healthy point of view about their bodies and medical conditions and understanding the relationship between physical and mental health;~~
- ~~Client education on how to talk to their doctors and feel heard, to be aware of their medical conditions and to be proactive in preventive care;~~
- ~~Encouragement to use their PCP and not the ER for routine health care needs;~~
- ~~Documentation of Client medical profile fields and ensure medical/wellness goals are addressed in an Integrated treatment plan.~~

~~All CSA staff will go through an comprehensive training that includes program specifications and requirements; Credible orientation and utilization; conducting Comprehensive Assessments; Care Plan and the role of the Care Team; Risk Management and safety planning; area specific community resources; Peer Support; Engagement, Building Relationships & Boundaries; Cultural competency and serving linguistic minority populations (including Deaf/Hard of hearing); and the four CSO Integrated Care Modules (see below), and Nonviolent Crisis Intervention using CPI (Crisis Prevention Institute). CSA staff will also be encouraged to attend EBP trainings such as Motivational Interviewing, Seeking Safety, SBIRT administration and interpretation, and others as offered.~~

~~b. Operational Infrastructure~~

~~CSO will work with other service providers, the consumer advisory board, and community stakeholders to identify areas to strengthen relationships and expand connections to the community. The CSO Program Director and Senior Family Partner will engage in community outreach activities and be charged with following through with linkages to needed resources. CSA staff will participate in regular staff meetings, of which community resources and connections to stakeholders will be regularly reviewed and shared. The Program Director also hold the responsibility of reviewing community needs and collaborators. Resource guides will be made available to CSA staff, and web based search libraries will be encouraged as resources.~~

c. Technology Innovation

Deliverables include the hardware and software enhancements described below in subsection (5)

5. Specific use of DSRIP funding the Bidder plans to make in order to execute the project and an explanation of how each investment will support the execution of the project goals;

Preparation budget period: $99,140

Goal 1: Training and Workforce Development

Cost of Trainer: $9,225

Cost of care coordinators: $8,610

Training supplies: $1,000

~~b. Operational Support~~

~~Outreach worker: $6,150~~

~~New recruitment strategies: $9,000~~

Goal 2: Technology

Technology purchases: $70,000

- ~~Desktop PC~~
- 2-1 notebooks for 15 staff $9,000
- Smart boards - 1 per site $6,000
- Enhancements to Credible to include CANS integration - $55,000
- ~~Smart phones with data plan~~

~~**Budget period 1: $88,030**~~
~~Goal 1: Training: $35,670~~
~~Cost of Trainer: $18,450~~
~~Cost of care coordinators: $17,220~~
~~Training supplies: $2,400~~
~~b. Operational Support~~
~~Outreach worker: $6,150~~
~~New recruitment strategies: $9,000~~

~~Budget period 2: 32,100~~
~~a. Training~~
~~Cost of Trainer: $8,160~~
~~Cost of care coordinators: $8,160~~
~~Training supplies: $2,400~~
~~b. Operational Support~~
~~Outreach worker: $6,150~~
~~New recruitment strategies: $9,000~~
~~c. Technology~~
~~Budget period 3: 19,260~~
~~Budget period 4: 12,840~~
~~Budget period 5: 6,420~~

~~All technology hardware purchase is in the prep period, along with some recruitment, outreach and training.~~

~~There is a focus on training in Years 1 – 5 - to enhance integration; improve retention; and increase quality (including Comprehensive Assessment quality).~~
~~Technology funds for years 1 – 5 mostly recurring license fees and Credible maintenance fees to support Credible connect and CANS integration data plan for cell phones, etc – which agency will start to absorb and "sustain" as project goes forth.~~

6. Existing internal resources (e.g., funding, staff, business site, IT systems, hardware) the Bidder plans to use to implement the project

a. Workforce Development

Our extensive training program facilitates the acquisition of new skills and certifications in order that staff may seek higher levels of professional attainment. Cross training is one means of creating flexible staffing resources. Our staff can move from program to program and have found it an excellent strategy for professional development. Through the development of a multi-disciplinary and multi-level staff Training Committee, CSO continues to invest significant labor and financial resources to an agency-wide training and professional development series. Trainings are targeted to both management development and multi-level direct care staff (including professional, clinical level as well as non-professional, case manager and direct service level), with a focus on improving quality of services. CEUs from NASW and NBCC are offered when applicable for agency staff, free of

charge. In-house trainings have been well attended and well received, and have significantly contributed to quality initiatives over the past year. CSO also offers $200 per employee available for the support of outside professional development opportunities, or for the purpose of encouraging licensing.

The training committee meets on a monthly basis to continue to evaluate trainings within the agency, as well as assess needs and plan for future events. Direct service staff are surveyed annually to provide feedback on training needs, suggestions and requests for further training. Training requirements from specific programs and funding agencies are integrated into training calendars. We have a video conferencing system with classrooms across our five outpatient sites that allow us to do virtual training for all staff, regardless of location.

~~**b. Operational Infrastructure**~~

~~We have been operating the CSA program since 2009 and have recruited trained and deployed many family partners to function in peer programming roles. We also have excellent working relationships with pediatricians, schools, family support providers, recreational providers and other community resources upon which we can build an enhanced and targeted outreach initiative.~~

c. Technology Innovation

CSO's EHR, Credible, supports care coordination with its integrated platform (primary care/medical profiles; mental health and substance abuse; e-labs; e-prescribing; client portal and provider portal, and a designated "case manager" role within the system that allows for case management across service levels/types). The new "Credible Plan," which is a truly integrated treatment plan that pulls goals and outcomes from all programs into a single, coordinated Care plan, is scheduled for release by September 2017 and will be used by all CSO programs. Upgrades to Credible will allow for CCD information and Credible Plan to be shared across PCP/ACO networks, as well as sharing of CANS outcome data and enhanced reporting capacity on such data.

As an EHR Credible creates an environment that facilitates internal care coordination and care management through use of single client record across enrolled programs. It also:

- Allows for collaboration with external providers- Integrated care model; Care management platform; provider portal and client portals with access determined by the client.
- Treatment Planning Module- Allows for care planning and documentation across multiple programs
- Employee Messaging, Client Warnings, Administrative Notes, Notification Triggers, "To Do" List- Multiple tools to support care coordination between multiple levels of care and across agency
- Mobile Care App (IOS/Android) – Credible's mobile app is a tool that integrates with the web-based version of Credible that allows providers to securely access encrypted clinical data while providing services in the community, either on- or off-line.
- Provider Portal, Client Portal, Direct Messaging, Summary of Care, eFax, collaboration with external providers to support consumers in navigating BH system of care. With appropriate releases, allows for direct exchange of data and forms within the portal.
- Business Intelligence (BI)- Fully configurable reporting tool to create custom reports, custom dashboards, and graphical reporting functionality for distribution. BI is a powerful tool for reporting with regard to identifying patterns and trends and assessing the needs of the communities we serve, including ability to identify medically complex individuals and patterns and trends. BI has the capacity to pull internal AND external feeds of data to create reports, analysis and population management capacity.
- Dashboards- Present targeted data in consumable format for day-to-day operations. Empowers staff with the ability to access, analyze, and report on data in a streamlined, efficient manner.
- eRx- ePrescribing (SureScripts certified): Credible eRx provides: a fully integrated drug database; reduced medication errors; monographs, contraindications, drug/drug interactions; drug/allergy interactions; generic equivalents, recommended dosage, and prescriber favorites; electronic submission to pharmacies; and identity proofing for prescribers.

7. An explanation of how funds will be allocated across the organization, and CSA site(s)

The CSA program is considered one "site" and the training and technology systems are centralized so there need not be any allocation of funds across sites. The training funds will be spent on one trainer and associated cost items. Our technology support investments are, by their nature, centralized with information and functions distributed across all internal users, with some functions available to external uses.

8. The internal evaluation, measurement or performance management strategies

CSO holds that its mission can be realized through the delivery of high quality programs and services in combination with advocacy efforts within a multi-level systematic approach. Quality Assurance and Continuous Quality Improvements are essential elements of CSO's operations. To support clinical best practice and innovation, CSO has established structures and processes that cultivate continuous learning. We support an organization-wide climate where feedback is freely exchanged. Employees have a clear, shared vision of the organization's goals and values. Staff get time to inquire and reflect about what they are doing and why, as well as having access to a broad range of training and professional development options.

CSO has the capacity to collect, report, and track encounter, outcome, and quality data, including but not limited to data capturing: (1) Enrollee characteristics; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) individual outcomes. Our internal Quality Improvement process begins with the data and information we collect related to our outcome measures and targets. We perform reviews of regulatory compliance and compliance with clinical standards and develop corrective measures if needed. We administer consumer satisfaction surveys annually by program to help identify issues coming out of consumer experience. Adherence to program policy and regulatory compliance are part of ongoing monitoring of quality. Treatment plans are reviewed regularly and charts reviewed during weekly Care Plan Team meetings. Systems to identify high-risk clients have been developed and implemented that trigger a high-risk case review, associated safety plan and updated treatment plan. We use weekly executive team meetings and department head meetings, and monthly reports to the Board of Directors meetings, consumer/staff planning committees and consumer program evaluations to evaluate our progress toward established benchmarks.

We will gather and analyze the data starting Q1 and ongoing to establish regular quality initiatives and establish measures of success:

- Tracking of critical client/consumer information
- Consumer outcomes, including CANS, medical and BH metrics
- Seamlessly view documentation, treatment plans, ISPs, and demographic data
- Set up to prioritize integrated care, with medical history, medical records, problem lists and medication information
- Data captured is both live and historical for key factors needed to support needs of medically complex individual
- Reporting on access benchmarks, utilization benchmarks, and clinical quality indicators (e.g.; ER utilization; cost utilization; time between intake and assessment; risk assessment; risk analysis; etc).

To evaluate training, attendance logs with trainee contact information will be collected, collated and logged. This data will be forwarded to the Master Trainer who will aggregate the information and forward it to the QA director for analysis and reporting. Increases in staff skills, knowledge and expertise will be measured using pre- and post-test questionnaires.

To evaluate enhanced job performance of trained staff, the CSO supervision process includes assessment, individual and group sessions, live coaching, documentation review, grand rounds participation, and performance reviews. Performance Improvement coaching is a tool that may be used to identify performance deficiencies and specify corrective procedures to facilitate that employee's improvement and, hopefully, his or her ultimate success within the organization. Performance reviews are utilized as a step in performance evaluation, and to jointly create performance goals and professional development plans.

Improved performance related to collaborative Comprehensive Assessments and Care Planning related to technology support will be measured by the Quality Management Director. Monitoring tools help to insure fidelity to the proven wraparound systems. CSO designs and re-designs program based on evidence-based models, evaluation studies and program outcome data. Peer observation and feedback, reflective practice and debriefing, and feedback loops based on data will help ensure quality and fidelity to practice as well.

To measure aspects of increased coordination with external providers in increase referrals and provide a timely access to ICC services, we will monitor communication among team members as documented in the medical record. We are able to evaluate random samples of patient charts over a specified period to verify that documentation of communication in the medical record is accurate, complete, clear, and concise. We will review and assess the effectiveness of communication within the care team and with outside providers.

B. Project Team description

For the proposed project(s), the Bidder shall describe its organization's level of readiness and proposed Project Team for implementing the proposed project(s), including:

*1. An organizational chart of the Bidder (as an attachment) that identifies personnel, senior managers, and other staff by titl*e

See attachment – Organizational Chart

2. A list of current staff that the Bidder proposes will be involved in the project(s), including their job descriptions and qualifications for the project(s)

The DSRIP Team consists of Sandi Walters, Associate Vice President of Community and Family Services, Joanne Jackson, Associate VP of Administrative Operations, and Mary Jo Crowley, CSA Director and Master Trainer.

See attachment immediately following this section – Job descriptions and resumes.

ATTACHMENT: JOB DESCRIPTIONS AND RESUMES:

JOB DESCRIPTION – Sandi Walters, LICSW

TITLE: ASSOCIATE VICE PRESIDENT, COMMUNITY AND FAMILY SERVICES

LINE OF RESPONSIBILITY: The Associate Vice President of Community and Family Services is directly responsible to the VP of Outpatient Services. The Care Coordination Directors, Family Resource Center Directors, and other related program directors report to the Associate Vice President of Community and Family Services.

PURPOSE: To provide clinical and administrative leadership and oversight of the Care Coordination, Community Service Agency, and other community based programs, including: day-to-day operations, fiscal management, program planning, development and expansion, quality improvement, compliance and evaluation.

ESSENTIAL RESPONSIBILITIES:

1. Provide or delegate administrative and clinical supervision for staff.
2. Consult and collaborate with other professionals providing services to consumers.
3. Develop and implement management systems to maximize staff productivity and efficient service delivery in all programs.
4. Consult with Medical Director to ensure the appropriate coordination and integration of clinical and medical services among programs.
5. Provide short- and long- program range planning and development; Provide leadership and technical assistance for program development and expansion or consolidation efforts.
6. Collect, record, and distribute statistical information and generate reports as necessary.
7. Participate in union contract negotiations and implementation with the senior management team, including hearing grievances.
8. Develop and implement managed care strategies for programs supervised and educate staff as to proper procedures and guidelines.
9. Monitor and assure compliance with all program policies and procedures, including program outcome measurements.
10. Participate in the Multi Disciplinary Review Team and ensure completion of all paperwork according to federal and state regulatory standards/timelines and agency standards/timelines.
11. Provide and/or review annual staff performance evaluations and assist staff in establishing and achieving professional goals. Provide performance management oversight and coaching on a continuous basis.
12. Conduct semi-annual program evaluation.
13. Participate in ongoing staff development and training opportunities in collaboration with Human Resources.
14. Collaborate with other CSO service directors, program managers and direct line staff as appropriate as related to program development, service delivery and practices in the achievement of agency mission.

15. Participate in regular budget meetings; ensure oversight of budget revenue and expense items.
16. Consult with the Chief Financial Officer as needed and ensure fiscal controls and systems are in place, and programs are fiscally viable.
17. Monitor utilization of contracts related to acute and residential programs (including local, state and grant funded programs); ensure that contractual obligations (programmatically and fiscally) are being met.
18. Participate in agency-wide Quality Improvement initiatives.
19. Participate in ongoing meetings with MBHP, DCF, DMH, law enforcement, other providers, community coalitions, etc. to develop and maintain positive working relationships and to maintain effective service delivery.
20. Participate in contract and/or grant writing, negotiation, and implementation.
21. Provide external networking for positive community awareness and connection to the agency.
22. Recruit, hire, train, and fire program staff, including clinical/direct care staff and support staff.
23. Conduct regular staff meetings.
24. Ensure compliance with regulations of state and federal agencies, including DMH, DPH, MBHP, etc.
25. Remain abreast of current trends in clinical and administrative practices related to their programs.
26. Support and maintains a high performance environment characterized by positive leadership and a strong team orientation as a member of the Senior Management Team.
27. Serve as an added value member of Agency Management Team through a demonstrated collaborative, cooperative, supportive and flexible attitude, sharing a fundamental philosophy that enhances the agency's global reputation within the community.
28. Communicate regularly with staff on progress toward defined goals of Management Team; provide specific feedback and initiates corrective action when defined goals and/or required results are not met.
29. Motivate staff to embrace the philosophies and goals of the Agency Management Team.
30. Perform other duties as assigned by supervisor or designee.

QUALIFICATIONS: Clinical Master's degree and independent license (LICSW or equivalent) with at least five years experience in the evaluation and treatment of children, adolescents, adults, and families, and mental illness; extensive knowledge of Care Coordination programs and models; at least five years of Senior supervisory and management experience, including: fiscal management (monitoring of state contracts and commercial insurances and monitoring of program budgets) and supervising staff; extensive knowledge of Mass Health, DCF and DMH; experience with Utilization Review and Quality Improvement; grant writing skills. Excellent clinical, interpersonal, organizational, and administrative skills. Computer proficiency required including ability to work with email, electronic health record and word processing software.

Resume: Sandi Walters, LICSW

Professional Summary

Licensed Independent Clinical Social Worker with twenty-five years of experience in various Behavioral Health settings with thirteen years of Sr. Management experience. Strong track record of building quality programs/staffing with solid relationships and collaborations with community partners, colleagues and funders.

SKILL HIGHLIGHTS

Program Development	Communication Skills
Demonstrated Leadership	Agency Trainer
Productivity/Budget Mgmt.	Community engagement and Partnership

Professional Experience

Vice President of Community Services **5 /2009-current**

Clinical & Support Options, Northampton MA

Oversight, development and management of Care Coordination programming

Oversight and management of Children's Behavioral Health Initiative Services (CBHI) and Amherst Family Resource Center

CBHI Programs include : Community Service Agency (Intensive Care Coordination/ wraparound services), In-Home Therapy, Therapeutic Mentoring, and Family Support & Training.

Managed up to 80 staff including a large supervisor team.

Hiring, recruiting, supervision and training oversight for multi-site and programs.

Maintain excellent standards and relationships with managed care entities and Network Management Team.

Facilitated three System of Care groups across the CSA designated area.

Built strong alliances with system partners such as DCF, DMH, Managed Care Entities, Community Coalitions and local community providers

Clinic Director- MSPCC, Greenfield, MA **11/2003-4/2009**

Managed the daily operations of a large outpatient behavioral health clinic including psychiatry, home visiting programs and FST (family stabilizations teams)

Clinical Supervisor /Intake Director
MSPCC, Springfield, MA **1/2001-11/2003**

Provided outreach clinical services to children and families

Clinical Supervisor for OP staff

Intake, Assessment and Risk Management
Oversight of Regional Intake Dept. to triage and refer to appropriate services including clinical and community supports

Family Based Services Coordinator
The Key Program, Springfield, MA **11/2000-1/2001**

Service Coordinator for DCF's Family Based Services contract
Co-location at the DCF office
Managed referrals and provider network concerns
Utilization review with network service providers

Care Coordinator/Case Manager **7/1993-9/1999**

Case Management and Intake for Inpatient and IOP programming for adult Substance Use Programs
Facilitated psychoeducation groups and group therapy for IOP
Hired, trained and supervised a team of three Care Coordinators
Responsible for systems for authorization and review with managed care

Education and Training

MSW- Temple University, Philadelphia, PA	**1999**
Licensed Independent Social Worker	**2003**
Bachelor of Arts- Psychology, Millersville University, PA	**1993**

Evidenced Based Training:
Attachment, Regulation & Competency
Trauma Focused CBT

Certifications:
Trauma Informed Care Certification Advanced Practice
Vroon Vandenburg Wraparound Tier I

Community Service

Member- DCF Greenfield Area Board, 2013-current
Member- Rotary Club of Franklin Co., 2010 to present
Member- North Quabbin Community Coalition Board, 2016- present
Turners Falls High School- Wellness Committee 2016- present
PTO- past member Erving Elementary School 2004-2009

JOB DESCRIPTION – Joanne Jackson

TITLE: ASSOCIATE VICE PRESIDENT, ADMINISTRATIVE OPERATIONS

PURPOSE: To oversee the agency's IT, Business systems, purchasing, and facilities departments and ensure maximum efficiency of administrative operations. The Associate Vice President of Administrative Operations is responsible for interfacing with technical consultants and vendors on behalf of the agency, manage the agency banking operations, and providing statistical reports to management on a scheduled and ad-hoc basis. The Associate Vice President of Administrative Operations also assists the CFO in ensuring setup of proper internal controls related to administrative and technological operations, and alerts management to potential problems.

LINE OF RESPONSIBILITY: The Associate Vice President of Administrative Operations reports to the Chief Financial Officer. The Facilities Manager, IT Manager and Purchasing staff report directly to the Associate Vice President of Administrative Operations.

ESSENTIAL RESPONSIBILITIES:

1. Supervise and oversee agency's day-to-day operations related to purchasing, facilities and IT functions.
2. Oversee and supervise network administration to control access to computer systems and to maintain security and compliance with technology usage policy; make recommendations to CFO and CEO on agency's technology needs and related benefits, options and cost analyses.
3. Oversee maintenance of all computer systems, hardware, and software for the agency.
4. Oversee facility maintenance at all agency worksites.
5. Work with software vendors to resolve problems and to develop new reports as needed.
6. Negotiate and oversee leasing and service agreements for all organizational electronic devices, office equipment, telecommunication hardware and software or other items as requested by CFO.
7. Possess working knowledge of all agency software including billing, EHR, accounting and payroll systems, and ensure staff have appropriate training and supervision to utilize such software/systems with maximum efficiency.
8. Ensure proper creation and maintenance of reports as required to satisfy needs of organization.
9. Work on special projects related to department as requested by CFO or CEO.
10. Conduct interviews for vacant positions within the departments; work with HR to recommend personnel actions as required, including hiring, transfers, promotions, discipline, or dismissal.
11. Provide ongoing supervision to administrative staff and ensure regular departmental supervision meetings occur.
12. Attend staff and Senior/Agency Management meetings as directed/scheduled.
13. Adhere to the philosophy of "customer satisfaction" and consistently follow the same by providing reliable, responsive, consistent and high quality service in a timely manner to staff and external customers.

14. Support and maintain a high performance environment characterized by positive leadership and a strong team orientation as an added value member of the Senior/Agency Management team; support CEO-approved goals and philosophies, sharing a fundamental philosophy that enhances the agency's global reputation within the community.
15. Communicate regularly with staff on progress toward defined goals of Senior/Agency Management team; complete and conduct annual performance evaluations in a timely fashion, providing specific feedback and work with HR to initiate corrective action when defined goals and/or required results are not met.
16. Motivate staff to embrace the philosophies and goals of the Senior Management team.
17. Perform other duties as assigned by supervisor.

QUALIFICATIONS: College degree in a related area of study or equivalent experience, and three years' management and supervisory experience in MIS and billing, preferably in behavioral health or related field. Working knowledge of electronic billing and payroll software/systems in addition to the ability to work with email and word processing software. Excellent oral and written communication skills. Ability to work independently and follow through with projects. Ability to perform multiple tasks and assignments over an extended period of time; understand and relate ideas and concepts; and identify and prioritize issues in a responsible manner. Ability to function effectively as a member of the Senior/Agency Management team with demonstrated collaborative, cooperative, supportive and flexible attitude. Must possess valid driver's license and reliable transportation.

Resume: Joanne Jackson

Experience

2016 - Present Clinical & Support Options, Inc.Northampton, MA
Associate VP of Administrative Operations

- Oversee the agency's Business Systems, Information Technology, Purchasing, and Facilities departments and ensure maximum efficiency of administrative operations.
- Manage system integration and new system implementations as they relate to existing systems.
- Assists the CFO in ensuring setup of proper internal controls related to administrative and technological operations, and alerts management to potential areas of risk.

2006 - 2016 Clinical & Support Options, Inc.Northampton, MA
Director of Administrative Operations

- Oversee the agency's Business Systems, Information Technology, Payroll, and Facilities departments and ensure maximum efficiency of administrative operations.
- Responsible for interfacing with all technical consultants and vendors on behalf of the agency.
- Assists the CFO in ensuring setup of proper internal controls related to administrative and technological operations, and alerts management to potential areas of risk.

2005 - 2006 Clinical & Support Options, Inc.Northampton, MA
Information Technology Manager

Managed and maintained a network, multiple servers, and sites.

2000 - 2005 Lyon Travel Agency, Inc. Brattleboro, VT
Information Systems Manager

- Managed and maintained a network of 75 users, multiple servers, and IS staff.
- Played a major role in the design, installation, and ongoing maintenance of a new 20,000 sq. ft. facility with the placement of new hardware.
- Suggested and designed new software applications for development to increase productivity and replace out dated systems.
- Managed the import process of several client data formats into SQL database for use in a custom written travel management database application.
- Trained and supported staff as new systems were developed and implemented.

1999 - 2000 Lyon Travel Agency, Inc. Brattleboro, VT
Technical Support Specialist

- Supported new custom application for users as well as assisted in the day-to-day network administration. Phone, e-mail, and face-to-face support
- Created training curriculum, materials, scheduled and performed training sessions for staff.

1997 – 1998 International Software ProductsBrattleboro, VT
Technical Support Specialist

- Supported and assisted users with installation and use of software via phone.

- Traveled for on-site installations, training and system troubleshooting.
- Created training materials and assisted in beta testing software.

1994 - 1997 Phoenix Insurance CompanyGreenfield, MA
Group Policyholder Customer Service Representative

- Serviced customers, communicating verbally and in writing to insurance policy inquiries.

Education

1991 - 1994 Greenfield Community College
A.S., Computer Information Systems

Certifications 2016 - Certified Youth Mental Health First Aid Trainer (Active)

JOB DESCRIPTION – Mary-Jo Crowley-Bowdish, LICSW

TITLE: CSA DIRECTOR/TRAINING COORDINATOR OF INTENSIVE CARE COORDINATION

PURPOSE: To provide daily administrative and programmatic oversight of the Intensive Care Coordination Program including program leadership, integration with other CBHI Services, and supervision of the Greenfield ICC Team. Additionally, the Assistant Director/Training Coordinator is responsible for the design and implementation of orientation and training of ICC Program Staff. The ICC Assistant Director Training Coordinator is knowledgeable of Systems of Care philosophy and the Wraparound planning process informing partnerships with families and skilled coordination of services. The ICC Assistant Director/Training Coordinator also oversees Family Support and Training services, both within ICC and standalone FS&T. This includes collaborating closely with CSO's subcontracted FS&T providers.

LINE OF RESPONSIBILITY: The Assistant Director/Training Coordinator of Intensive Care Coordination reports to the Family Support Services Director.

ESSENTIAL RESPONSIBILITIES:

1. Provide regular administrative, clinical, and care coordination supervision to intensive care coordination staff including Family Partners.
2. Provide education and direction for successful implementation of Wraparound services.
3. Work collaboratively to coordinate program development and teambuilding with all ICC staff, including Family Partners.
4. Provide clinical consultation and guidance to ICC staff, ensuring clinically informed care plans for children and families.
5. Facilitate care planning team (CPT) meetings as necessary and educate staff on the facilitation of meetings.
6. Oversee supervision of Care Coordinators at all three sites in order to provide consistent, quality and informed services throughout the CSA.
7. To oversee orientation of new staff to Wraparound in the first four weeks of employment and to work closely with site ICC supervisors to train and credential new ICC and FP staff within 6-9 months of employment.
8. To supervise and monitor the STAY together grant from DMH.
9. Assist ICC Supervisors and Senior Family Partners in learning the training/credentialing process to develop a team of trainers.
10. Provide direct delivery of intensive care coordination services as needed, including comprehensive home-based assessment inclusive of the CANS, family-driven identification of appropriate members of the care planning team (CPT), collaboration with a Family Partner who provides family support and training, development and implementation of a youth- and family-centered intensive care plan (ICP), and development of a risk management/safety plans.
11. Provide assistance to staff and community participants with systems navigation and coordination.

12. Provide community education regarding Wraparound services, intensive care coordination and the CSA.
13. Be available to work flexible schedule which may include evening and weekend work and availability by phone or pager to supervise and assist with plan implementation, as required by the needs of the program.
14. Utilize clinical and training expertise to provide leadership and guidance to staff, families and care planning teams for complex family presentations requiring advanced clinical management skills.
15. Act as a resource to ICC Supervisors during the CSA credentialing process.
16. Maintain complete, accurate and timely records.
17. Maintain regular communication with MCE's (managed care entities) and third party providers.
18. Meet expected productivity level when direct service is required.
19. Attend staff and Agency Management meetings as directed.
20. Adhere to the philosophy of "customer satisfaction" and consistently follow the same by providing reliable, responsive, consistent and high quality service in a timely manner to staff and external customers.
21. Support and maintain a high performance environment characterized by positive leadership and a strong team orientation as an added value member of the Agency Management team; support CEO-approved goals and philosophies, sharing a fundamental philosophy that enhances the agency's global reputation within the community.
22. Communicate regularly with staff on progress toward defined goals of Agency Management team; if required, complete and conduct annual performance evaluations in a timely fashion, providing specific feedback and work with HR to initiate corrective action when defined goals and/or required results are not met.
23. Motivate staff to embrace the philosophies and goals of the Agency Management team.
24. Attend all scheduled individual and group supervision.
25. Follow all agency policies and procedures.
26. Perform other duties as assigned by supervisor.

QUALIFICATIONS: Masters Degree in Psychology, Counseling, or closely related field from an accredited program. The care coordinator is skilled in providing education and planning regarding treatment access and service needs, parenting skills, conflict resolution mediation, risk management/safety planning, family advocacy and support. Demonstrated experience working with children, adolescents and families, including experience navigating children's systems and supports within the community. Knowledge of and training in child development and children's mental health experience. Good listening skills, nonjudgmental ability to foster self-sufficiency; desire to work in natural family and youth settings. Ability to establish trusting relationships through compassion, empathy and insight. Be an effective member of a Team. Demonstrated sensitivity to the needs of families from diverse cultural or linguistic backgrounds. Computer proficiency required including ability to work with email, electronic health record and word processing software.

Resume: Mary-Jo Crowley-Bowdish, MSW, LICSW

PROFILE

- Experienced and skilled clinical supervisor.
- Dedicated to respectful, collaborative, trauma informed, strength based practice.
- Strong background in clinical intervention with diverse populations.

EDUCATION

Master of Social Work
Springfield College School of Social Work, Springfield, MA, 2004

Bachelor of Science, Human Service Administration
American International College, Springfield, MA, 2002

LICENSURE

Licensed Independent Clinical Social Worker # 113778 MA

EXPERIENCE

ASSISTANT DIRECTOR/TRAINING COORDINATOR FOR THE CSA 2009-Present
Clinical & Support Options, Massachusetts

- Provide regular administrative, clinical, and care coordination supervision to all CSA staff.
- Train CSA staff to be Tier 1 certified.
- Provide ongoing education, training and direction to ensure high fidelity wraparound.
- Provide assistance to staff and community members with systems navigation and coordination.
- Provide individual supervision to the CSA supervisory team.
- Review Individual Comprehensive Assessments including Child and Adolescent Needs and Strengths (CANS**),** Individual Care Plans, and Strength Needs Culture Discovery Assessments.
- Provide presentations of the Wraparound Process to community providers including schools, clinics, police departments, crisis teams, primary care physicians and state agencies.
- Provide individual, dyad, and team supervision for CSA staff.

CLINICAL THERAPIST 2008-2009
Maple Valley School, Wendell, Massachusetts 01379
Victory House Behavioral Therapeutic Residence**,** Greenfield, Massachusetts, 01301

- Provided individual, family and DBT group therapy.
- Provided treatment for youth with sexualized and fire setting behavior.
- Collaborated with providers within the milieu, and in the community.
- Attended IEP meetings and worked closely with the public schools.
- Completed client assessments, including diagnostic and clinical formulations.
- Developed strength based treatment plans and behavioral incentive plans.
- Provided consultation to all direct care staff.
- Supervised Masters level student interns.

FAMILY STABILIZATION CLINICIAN 2003-2008
Massachusetts Society for the Prevention of Cruelty to Children, Greenfield, Massachusetts, 01301

- Provided individual and family therapy for high risk children and their families.
- Collaborated with providers within the agency and in the community.
- Developed individual treatment plans, behavioral incentive plans, and crisis plans for each child.
- Supported children and parents in their schools by attending IEP meetings and providing recommendations for school based interventions.

INTAKE CLINICIAN

- Provided individual and family therapy for individuals of all ages.
- Completed diagnostic assessments and comprehensive treatment plans.
- Monitored client progress using the Treatment Outcome Package (TOP), and the Child and Adolescent Functional Assessment Scale (CAFAS).

CERTIFICATIONS

- Credentialed as a Tier One and Tier Two Wraparound Facilitator, Vroon VDB, LLC.
- Credentialed as a National Wraparound Coach, Vroon VDB, LLC.
- Child and Adolescent Needs and Strengths (CANS**)** certified.

3. Any staff the Bidder proposes to hire or engage to be involved in the project(s), including their proposed job descriptions and qualifications for the project(s)
Not applicable
4. The roles and responsibilities of each staff of the Bidder's Project Team and how the Bidder will ensure efforts are coordinated among staff and not duplicated
- As Team leader, Sandi Walters will oversee the entire DSRIP implementation process in terms of timelines and deliverables and will directly supervise the outreach effort of the Senior Family Partner.
- Mary-Jo Crowley will oversee the planning and implementation of the full training curriculum and will serve as the Master Trainer.
- Joanne Jackson will over the specification, purchase and installation of technology hardware and will coordinate with Mary-Jo Crowley on training initiatives so that staff will be able to make optimal use of technology in enhancing the Comprehensive Assessment process.
5. A description of how the Bidder proposes to manage the project(s)
Project Team: We will have well established executive level communication channels, and well developed policies and procedures for the program, designed to minimize and prevent conflict. The Team will be supervised by CSO Associate Vice President Sandi Walters, LICSW. During the implementation of the DSRIP projects, the Team Leader will convene a meeting of the managers on a monthly basis, to discuss progress of the program, confer about issues—whether recruitment, technical, clinical, inter-agency, or other—share ideas about corrections or improvements and generally develop a team identity and culture that will support these projects. Ms. Walters will be easily accessible to the Team by cell phone, text and email.

C. Implementation Plan and Timeline

Preparation Period			
Month One	***Key Action Steps***	***Person Responsible***	***Timeframe***
Convene DSRIP Project Team (DPT)	At initial meeting, DPT will review implementation plan and revise if needed	Sandi Walters (SW) (VP co-leading DPT)	Within 3 business days of award announcement DPT will meet bi-weekly during planning period
Review Credible (EHR) plan for status with regard to DSRIP projects	Identify status of necessary system enhancements & refinements	SW & Business Systems team	Complete w/in 30 days
Establish Policies/Procedures for new communication and collaborations	Identify P/Ps needed for DSRIP in addition to established P/Ps;	Karin Jeffers (KJ) (CEO), SW and appointees TBD by CEO	Appointed w/in 14 days of award
Develop Training Plan	Develop course offering and training schedule	Mary Jo Crowley (MJC) and SW	By end of month one
Month Two	***Key Action Steps***	***Person Responsible***	***Timeframe***
Identify and prep Family	Develop cross-section of	SW and Family Partner	Beginning of

Partner	existing and potential partners to contact		month two
Identify organizations targeted for outreach	Develop contacts list	SW and Family Partner	Beginning of month two
Identify hardware needs	Develop inventory of needed Smartboard and other technology equipment, order and purchase.	Joanna Jackson (JJ)	Mid-month two
Identify training participants	Recruit and notify staff who will be attending each set of trainings.	MJC	Beginning of month two
Test Credible processes for care coordination and provider portals	Per plan	JJ	ongoing
Convene CQI Exec Committee	Review QI requirements for project; develop program-specific plan	Ariane Krumholz (AK), QI Director	By end of month two
Develop informational materials customized for different stakeholders (e.g., members, referral partners)	Identify all products needed Design & produce them	Dir of Marketing with review by KJ, SW and DPT members	By end of month two
Contact ACO/MCOs	Identify ongoing contacts for various functions and collaborations; orient to DSRIP projects	KJ, SW	By end of month two
DPT reviews status of all prep sub-systems and activities	Revise or take corrective action as necessary DPT reviews revisions of P/Ps	SW, DE, DSRIP Dir convene	Mid-month two By end of month two
Month Three	***Key Action Steps***	***Person Responsible***	***Timeframe***
Begin outreach to ACOs/MCOs	Meet with designated leaders of ACOs/MCOs in CSA service area	SW and Family Partner	ongoing
Implement equipment installation at sites	Per plan	JJ & operations team	ongoing
Finalize training plan	Review all curricula, identify instructors Establish training schedule	Melody Arsenault (MA) (VP-HR), SW, MJC	By mid-month three
Review site set-ups	All space for staff made fully functional	JJ & operations team	By end of month three
Review QI plan for DSRIP	Develop data collection, monitoring & reporting workflows	AK & SW	By end of month three
Test Credible revisions	Per plan	DSRIP Project Team	ongoing
Reviews status of all prep activities	Revise or take corrective action as necessary	DSRIP Project Team	Mid-month three
Month Four	***Key Action Steps***	***Person Responsible***	***Timeframe***
DPT reviews status of all prep sub-systems and activities	Revise or take corrective action as necessary	DSRIP Team convenes	Beginning month four
Conduct in-service training	Deliver training per plan	MJC	ongoing

for all staff (on all topics identified in this proposal)			
Begin training	Initiate training session	MaASW and MJC	By end of month four
Outreach to community referral partners	Provide information about CSA services, contacts Ensure our understanding of their services, availability, eligibility red's, referral process	SW, Family Partner	ongoing
Finalize Credible p/p	Test with users	JJ & Business Systems team	By end of month four
Month Five	***Key Action Steps***	***Person Responsible***	***Timeframe***
Orient community partners	Provide orientation and schedule training sessions with providers	MJC and SW	By mid-month five
Complete initial round of training for all DSRIP staff (on all topics identified in proposal)	Deliver training per plan	Managed by HR team & MJC	By end of month five
Enhance Comprehensive Assessment and Care Planning	Conduct a prototype collaborative sessions with Smartboard and other technology	SW, CPT and ICC staff	by end of month five.
Continue outreach to referral partners	Provide information about CSA services, contacts Ensure mutual understanding of services, availability, eligibility req'ts, referral process	SW, Family Partner	ongoing
DPT reviews status of all prep sub-systems and activities	Revise or take corrective action as necessary	SW, DE, DSRIP Dir convene	Mid-month five
Year Two – Year Five	***Key Action Steps***	***Person Responsible***	***Timeframe***
	Support new technology with licenses for SmartBoards and data plans for smart phones.	JJ	ongoing
Training	Continue training sessions	MJC	ongoing
CQI/Quality Assurance	Annual evaluation of DSRIP training and technology projects	DPT and SW with Dir. of Quality Mgmt	ongoing

D. Budget Report and Budget Narrative

See Attachment B and C for Budget Report and Budget Narrative, immediately following this page.

E. Sustainability

While sustainability is a challenge for any non-profit organization that is highly dependent on public funding, CSO has some advantages in place:

- Our cloud-based Electronic Health Record does not require high on-going maintenance fees. We have already completed the substantial initial investment and expect that future investments, beyond the term of the DSRIP contract, will be small enough to be covered by ongoing program revenue.
- Our administrative infrastructure, currently undergoing improvement to state-of-the-art technology for financial and HR management, is stable and sized to sustain reasonable growth in capacity.
- Our DSRIP projects all have the overall goals of capacity building and do not entail ongoing operations, rather, one-time investments.

CSO's executive management has demonstrated its strategic agility to grow and adapt services with the changing healthcare landscape, growing the organization from a budget of $5 million in 2005 to $35 million in FY 2017. This growth can be attributed:

- to having sights set on the future;
- cultivating and sustaining relationships with key organizational stakeholders locally and at the state level;
- having both the framework of a strategic plan and the flexibility to quickly move on strategic opportunities that arise unexpectedly; while
- continuously, vigorously attending to the quality and continual development of services; and
- cultivating and sustaining a high quality administrative management team and infrastructure.

Sustainability is further enhanced through our 2015 Strategic Plan which focused on updating and enhancing our administrative operations. This has been important, not only for improved efficiency and greater capacity, but also was critical to securing COA accreditation. COA scrutinizes many functional sectors: HR, training, IT, contract management, staffing and written policies and procedures for all programs. In the process, we redesigned workflows in HR, IT and finance department, added positions to assure appropriate separation of duties and to have sufficient resources to (1) assure regulatory compliance; (2) perform in accordance with our quality standards for timely responsiveness and adequate documentation; and (3) strengthen our capacity to manage operating risk.

We anticipate that these infrastructure improvements will continue to serve CSO in the next five years in the implementation of CSA DSRIP projects. CSO has established itself as a core provider for all the Mass Health MCOs and BH carve-out companies in western Mass. We expect to maintain our excellent reputation for service quality and responsiveness through the delivery system reform. Over the course of the 5-year DSRIP program, we will work with ACO/MCO, health care organizations and other organizations in the region to implement DSRIP projects.

We expect that efforts at relationship building and achieving shared understanding will serve CSO well over the course of CSA DSRIP implementation. We will work together with other System of Care stakeholders, as we all approach the end of the 5-year project, to develop new protocols, procedures and communications as well as conducting CQI on all the DSRIP initiatives. We will encourage our local system partners (ACOs, MCOs, CBOs,

schools, health providers, other behavioral health providers and consumer organizations) to meet with us (individually or collectively) regularly to work on meeting project goals.

6.5 COORDINATION WITH ACOS, MCOS, AND PRIMARY CARE PROVIDERS

A. Bidirectional communication between the Bidder and pediatric practices

~~CSO was fortunate in 2014 to secure a Workforce Training grant from the Commonwealth Corporation to enhance the skills of our workforce in providing integrated primary and behavioral health care. This undertaking has had the biggest impact on the agency in the realm of care coordination capacity. Two hundred members of our staff have participated in *Integrated Health Treatment Education and Training* (IHTET), a customized five-module training program to develop general skills for mental health practitioners/ professionals in engaging patients, promoting their self-efficacy to improve their own health, enhancing general medical/primary health knowledge to be able to connect clients to appropriate services, to address questions and to support client-directed integrated treatment planning that includes physical health and wellness goals. The most important aspect of this training program with regard to our CSA role is the coaching for our staff in communicating with primary care providers and pediatricians.~~

CSO will be working with ACO partners to set up notification systems between CSA staff and ACOs for ER visits, hospitalizations/ admissions to residential programs, discharge and follow-up as part of CBHI services. In the service areas where CSO is the ESP, we can track and notify any client hospitalized for psychiatric reasons. The CSO Business Systems team is working on an electronic notification exchange system that will include other facilities in addition to hospitals. Enhancements made to Credible will allow for CCD transmission, direct messaging of Credible Care Integrated plans and other CSA specific documents, and enhanced reporting on and sharing of CANS outcome data.

B. Referral management protocols for follow-up and informational sharing

CSO has a long history of engaging and collaborating with multiple MCOs and MCEs, and are confident that this success will apply to engagement with multiple ACOs as well if we are designated as a Community Partner. In additions wee will work with all CSA stakeholders as represented in Systems of Care, ACOs/MCOs and the State to help standardize processes as much as possible. We will assign referrals right away and notify the referring entity of the status of the referral and when and where intake will occur.

We will mutually develop conflict resolution strategies before any potential conflict arises, to assist in working through potential differences. We have well established executive level communication channels and well developed policies and procedures for referrals, designed to minimize and prevent conflict. We will have explicit and shared policies around updating Care Plans to that all team members and partners are aware of the child's and families' progress and further needs that are documented in Plan updates. As part of CQI, we will establish a process to analyze referral flow/caseload lists/productivity.

C. Team-based treatment planning in collaboration with pediatric practices

CPT team members are aware of the health history, status, and unique needs of the youth and family, and are assigned different responsibilities, which together are designed to result in continuous, comprehensive, coordinated care. As a result, all members of the team feel engaged in their key role of providing wraparound services. Communication between team members and pediatricians may be managed through the Credible Provider Portal\electronic messages, e-mails, or electronic notes in the health record.

We will document a policy and procedure for structured preparation and response to family issues by the Team in conjunction with the family's pediatrician and other providers. Based on the evaluation of communication between staff, we will develop a quality improvement process to address identified gaps and flaws in how communication is

exchanged. We will support all staff to work as a group to help develop action plans that will be implemented to improve communication processes in the practice.

D. Timely access to ICC services

~~Outreach by the Senior Family Partners (operational infrastructure project) with community providers will increase community awareness of ICC services and how to access them so that providers may make referrals with ease and with maximum communication and, where possible, by using CAO HER technology.~~ We will document a policy and procedure for structured preparation and response to family issues by the Team in conjunction with the family's pediatrician, other providers and ACOs. Based on the evaluation of communication between staff, we will develop a quality improvement process to address identified gaps and flaws in how communication is exchanged. We will support all staff to work as a group to help develop specific processes that will be implemented to improve communication processes in the program.

E. Connections to social services

Through our convening and/or participating in System of Care Committees, CSO has an extensive network of community organizations that we meet with regularly and whom are invited to participate in Care Planning Teams when involved with a family. This collaboration will be enhanced by the wraparound training of CSA staff (workforce development initiative) and support for collaborative Comprehensive Assessment and Care Planning processes (technology initiative.)

CSA Budget Report

Eliot Community Human Services, Inc.

Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites	1	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate	NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)	172	172	172	172	172	172	
Estimated Funds	$ 115,728.00	$ 120,400	$ 72,240	$ 51,600	$ 45,408	$ 20,640	**$ 426,016**
At- Risk Withhold Rate			5%	10%	15%	20%	
Withhold			$ 3,612	$ 5,160	$ 6,811	$ 4,128	**$ 19,711**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 115,728.00	$ 120,400	$ 68,628	$ 46,440	$ 38,597	$ 16,512	**$ 406,304.80**

Investment Projects	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Project 1 Name: *Training, Consultation, Recruitment and Retention Project*							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ 5,000	$ -	$ -	$ -	$ -	$ -	**$ 5,000**
Training Expenses	$ 12,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	**$ 37,000**
Retention Expenses	$ 5,000	$ -	$ -	$ -	$ -	$ -	**$ 5,000**
Operational Infrastructure							
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 1 Total	$ 22,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	**$ 47,000**
Project 2 Name: *Community Outreach and Intergration Project*							
DSRIP Goal(s) Addressed: Goal 1:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Goal 2:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure							
Operation Staffing including Fringe	$ 53,792	$ 72,982	$ 44,789	$ 31,278	$ 25,725	$ 3,511	**$ 232,077**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 2 Total	$ 53,792	$ 72,982	$ 44,789	$ 31,278	$ 25,725	$ 3,511	**$ 232,077**
Project 3 Name: *Software Development and Hardware Deployment Project*							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:							
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ 20,000	$ 25,000	$ 12,000	$ 8,000	$ 5,000	$ 5,000	**$ 75,000**
Technology for Service Delivery	$ 8,000	$ 5,000	$ 3,000	$ 2,000	$ 5,000	$ 5,000	**$ 28,000**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**

Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 3 Total		$ 28,000	$ 30,000	$ 15,000	$ 10,000	$ 10,000	$ 10,000	**$ 103,000**
Total Project Costs		$ 103,792	$ 107,982	$ 64,789	$ 46,278	$ 40,725	$ 18,511	**$ 382,077**
Indirect Costs/ Administrative Overhead Rate	11.5%	$ 11,936	$ 12,418	$ 7,451	$ 5,322	$ 4,683	$ 2,129	**$ 43,939**
Investment Projects Total		$ 115,728	$ 120,400	$ 72,240	$ 51,600	$ 45,408	$ 20,640	**$ 426,016**

CSA Budget Report - Budget Narrative Prep Budget Period

CSA_Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name: Training, Consultation, Recruitment and Retention Project

DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care planning,*
2 *(3) Improving timely access to ICC services for children eligible to receive ICC and*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Community Outreach and Integration Project

DSRIP Project Goal(s):
1 *(3) Improving timely access to ICC services for children eligible to receive ICC an*
2 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name: Software Development and Hardware Deployment Project

DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Purchase of Care Management Platform	$ 20,000.00
Total Development and Adaptation of EHR and Care Management System	$ 20,000.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined: Eliot will invest $20,000 of CSA DISRP funds , in tandem with approximately $80,000 of Community Partner DISRP funds, during the preparation budget period toward the purchase of the eHana Care Management Platform. The Care Management Platform is essential to the successful integrated care and will ensure data exchanges with ACO, MCOs, PCO's, the CSA, and EOHHS. The eHana system will focus on real time coordination between the CSA and PCPs, other providers, and enrolled children and families.

The budget prep period includes the bulk of the funding for software development. Decreasing levels of funding will be dedicated to EHR enhahncements in subsequent years.

Technology for Service Delivery

Description of Expense	Cost
Chromebooks x 8 units x $500 each	$ 4,000.00
Smartphones and Service x 8 units x $500	$ 4,000.00
Total Technology for Service Delivery	$ 8,000.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined: An additional $8,000 of DISRP funds will be used to purchase and deplot enhanced hardware for CSA staff, including smartphones and tablets to improve efficiency and effectiveness of care coordination efforts. These are one time purchases, and related expenses will not be covered through DISRP funds in subsequent years.

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Workforce Development - Prep Budget Period

Project 1 Name: Training, Consultation, Recruitme

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Recruitment	$ 5,000.00
Total Recruitment Expenses	$ 5,000.00

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined: During the budget prep period, ecruitment efforts supported by DISRP funds will include targeting advertising, marketing, promotional and informational material development, and other recruitment strategies in collaboration with Eliot's Workforce Development and Human Resources Departments. Targeted recruitment efforts will focus on BA and MA level ICC's , ideally with some experience with integrated health care; and Family Partners with experiencing navigating healthcare systems. Funding will support the development and printing of marketing materials to be sent via targeted direct mailing, social media marketing materials and enhance recruitment efforts through social media (LinkedIn, Facebook, Glassdoor, etc), and expansion of traditionally behavior helth focused in-person recruiting (ie: graduate schools of social work and psychology) to include new venues (general healthcare events, etc).

During subsequent years of DISRP funding, recruitment costs will no longer be included in this project.

Training Expenses

Description of Expense	Cost
Core training for new Eliot staff	$ 3,000.00
EBP Training for Eliot staff	$ 3,000.00
YMHFA and Enough Abuse Training for ACO/MCO	$ 6,000.00
Total Training Expenses	$ 12,000.00

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined: During the prep period, Eliot will invest an estimated $12,000 of DISRP funds in training and consultation. Training and consultation will include training for Eliot CSA workforce to increase staff knowledge and skill in effective care coordination and support in conjunction with ACO, MCO and PCO entities, targeted training for the Project Leadership Team, and for Eliot to provide trainings to ACO, MCO and PCO entities. Approximately $3000 will support enhanced new staff orientation and professional development trainings for CSA staff (includes 8 days of new staff orientation and monthly in service development traiings). Approximately $3000 will be dedicated to evidence based practice training including Youth Mental Health First Aid, Enough Abuse, evidence based practice models,. Approximately $6000 will support Eliot staff providing training to ACO, MCO, and PCO staff in Youth Mental Health First Aid and Enough Abuse curricula. (trainng cost per person for YMHFA is approximately $100, with a goal of training 50 staff at ACO/PCO/MCO practices; Enough Abuse cost is limited to Eliot staff time at a rate of approximately $200 per training , with a goal of facilitating 5 trainings).

During subsequent years of DISRP funding, a small portion of funding (approximately $5000 per year) will continue to be allocated to training and consultation with a focus on continued professional development and integration.

Retention Expenses

Description of Expense	Cost
Incentives	$ 2,000.00
Teambilding	$ 2,000.00
Development	$ 1,000.00
Total Retention Expenses	$ 5,000.00

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined: Based on the recognition that increased employee retention is directly correlated to enhanced quality of care, a portion of DISRP funds will be dedicated to efforts to increase retention of ICC's and Family Partners through performance based incentives, teambuilding, and professional development initiatives. Incentives include employee referral bonuses of $500 per new hire (estimated for 4 hires). Teambuilding initiatives will include 2 staff "retreats" with a focus on enhanced collaborations , both internal (ICC and FS&T partnerships, accessing expertise related to enhanced care coordination) and external (engaging staff at ACO/PCO/MCO entities through open houses , etc). The Development expense will include productivity adjustment for CSA staff to allow for non-billable activities such as attending meetings (staff meetings, in-services, and other non-client related activities) and events hosted by ACO/MCO/PCO entities, etc . In addition to the efforts of the Community integration and Outreach Coordinator, this will provide Cadditional CSA staff the opportunity to develop enhanced relationships with providers at ACO/MCO/PCO sites, and will enhance the professional development of the CSA staff.

Retention will remain a priority beyond the budget prep periond, but will not be supported by DISRP funds.

Project 2 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 1 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Director of Clinical Services	$ 100,000.00	0.20	5	$ 8,333.33
Project Lead	$ 85,000.00	0.25	5	$ 8,854.17
Community Outreach Liason	$ 63,100.00	1	5	$ 26,291.67
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		1.45		$ 43,479.17
	Fringe rate	23.7%	Total Fringe	$ 10,312.82
Total Program Staffing including Fringe				$ 53,791.99

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project: Eliot has identified a Project Team comprised of existing key staff connected to the CSA and Community Based Services. During the prep period, Eliot will dedicate a portion of DISRP funds to the offset a prorated portion of the salary of the Director of Clinical Services, and the Project Lead, Mederic McLaughlin. Eliot will hire a Community Integration Outreach Coordinator at an estimated salary of $63,100.00 , and use DISRP funds to fully cover prorated salary and fringe, allowing the position to focus exclusively on non-billable outreach and coordination efforts with ACO, MCO and PCO entities. During the prep period, these positions/portions of FTE's will target outreach to develop and foster collaborative relationships with ACO, MCO and PCO entities and begin to establish systems for enhanced screening and determination of eligibility for CSA services, referrals, and expedited follow up.
During subsequent years, the Project Lead will no longer be funded through DISRP, and the Community Integration/Outreach Liaison will be funded at continuously lower level each year as the position begins to generate revenue through billable services and can sustain itself.

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate: ~~$ 11,936.08~~

Provide a brief description of how the Indirect Cost/Administrative Overhead rate was determined:
The Agency's current allocation of indirect costs at 11.5% which is a calculation based on an analysis of our last 3 years of agency administrative expense as well as our projections for agency administration costs for the fiscal year. These costs include those non-program specific reimbursable resources necessary for policy making, management, oversight and administration of Eliot as a whole. In this category are general agency administrative expenses such as HR, Finance, Executive Management, and general infrastructure.

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS March 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y**	**If NO, please explain:**
					Technology	IT Staffing including Fringe								
3	Software Developmet and Hardware Deployment	Invest in the purchase/development of eHana Care Management Platform	09/01/17	05/31/18	**Technology**	Development Adaptation of EHR and/or Care Management System								
3	Software Developmet and Hardware Deployment	Purchase and deploy enhanced hardware technology to CSA staff	01/01/18	05/31/18	**Technology**	Technology for Service Delivery								
					Technology	Other Technology Expenses								
					Workforce Development	Workforce Development staffing including Fringe								
1	Training, Consultation, Recruitment & Retention	Hire and orient Community Integration & Outreach Coordinator	10/01/17	01/31/18	**Workforce Development**	Recruitment Expenses								
1	Training, Consultation, Recruitment & Retention	Train CSA workforce in Youth Mental Health First Aid and Enough Abuse	01/01/18	05/31/18	**Workforce Development**	Training Expenses								
1	Training, Consultation, Recruitment & Retention	Identify and implement staff appreciation, teambuilding, and development initiatives for CSA staff	01/01/18	05/31/18	**Workforce Development**	Retention Expenses								
2	Community Outreach & Integration Project	Hire and orient Community Integration & Outreach Coordinator	10/01/17	01/31/18	**Operational Infrastructure**	Operation Staffing including Fringe								
2	Community Outreach & Integration Project	Identify one ACO, MCO, or PCO site from each city/town in CSA catchment area	01/01/18	03/31/18	**Operational Infrastructure**	Other Operational Expenses								
					Operational Infrastructure	Other Operational Expenses								
2	Community Outreach & Integration Project	Negotiate and execute MOU/Affiliation Agreement with selected ACO, MCO, PCO sites	02/01/18	05/31/18	**Operational Infrastructure**	Other Operational Expenses								

Section 6.2 Executive Summary

A. Current performance on Development Plan

Eliot Community Human Services, Inc. (Eliot) is an agency that prides itself on educating, connecting and coordinating with, and supporting families, community partners and natural supports in combined efforts to improve the quality of life for those we serve. Eliot is committed to growing and learning to keep pace with new initiatives and models and the increasing complexity of those we serve in diverse cities and towns in the CSA's catchment area. The Agency is passionate about Intensive Care Coordination and Family Support and Training and understands the role its services have in ensuring children, youth and families have supports and resources that promote sustained success. Eliot is eager and excited to expand its partnerships with pediatric primary care physicians through this proposal. With a clear and exhaustive road map, Eliot is well positioned to further increase its footprint throughout the Northeast.

Constantly striving to improve, Eliot's Community Service Agency (CSA) efforts toward meeting goals established in its Development Plan have been proven successful. Since January 2017 the CSA has met the two goals of increasing youth voice on care plan teams and demonstrating increased effective teamwork. Although much progress has been made on the Development Plan's goals, there is more to be done in areas critical to solidifying a full complement of staff that will ensure timely access to all services for all youth. Eliot has developed a proposal which clearly outlines those areas which need to be addressed, identified aggressive timelines for completion over the next five years, created strong measures and outcomes for success and presented a sustainable model that will remain in place far beyond the length of the contract. Eliot firmly believes that funding to increase infrastructure and capacity building within the CSA will further advance these efforts and build upon a strong foundation of services.

B. Strengths and needs of Eliot

Eliot's strengths lie in its evidence based practice models and trainings that are recognized as best practices in the field, comprehensive and diverse infrastructure, and quality assurance systems that dictate a system for risk management and quality improvement.

Rooted in a deep commitment to individualized, strength based and trauma informed service delivery, Eliot has developed a comprehensive strategy for training and implementation of evidence based practices. Eliot has a network of clinicians trained in evidence based treatment models including, but not limited to, Trauma Focused Cognitive Behavioral Therapy (TFCBT), Attachment, Regulation and Competency (ARC), Alternatives for Families Cognitive Behavioral Therapy (AFCBT), Child Parent Psychotherapy (CPP) and Dialectical Behavior Therapy (DBT).

Youth Mental Health First Aid (YMHFA) training has been provided to all program administrators and staff by Eliot's eight certified YMHFA trainers. This nationally recognized training was developed to increase program staff's awareness of common adolescent mental health challenges such as anxiety, emotional and behavioral dysregulation and depression.

Eliot has recently partnered with MassKids to bring the Enough Abuse Campaign into our network of training resources and prevention. The curriculum addresses the recognition, prevention and intervention of child sexual abuse. Through a Train the Trainer Model Eliot has created a self-sustained network to ensure that every staff has initial and ongoing training relative to child abuse. In addition to training our internal workforce, trainers will facilitate trainings for community partners, including pediatric providers and ACO/MCOs.

Eliot is committed to Continuous Quality Improvement throughout all services, and has developed policies, procedures, and implemented infrastructure to support quality assurance initiatives including complex case reviews and multidisciplinary review teams. Eliot meets and exceeds standards for quality and outcome measurement set forth through contracts and funders.

Eliot's Children, Youth and Families Division has addressed its needs through a comprehensive Strategic Plan that formally identifies areas of growth, while highlighting responsibilities and aggressive timeframes for completion through tiered one, three and five year models. Current, short-term and long-term goals of Eliot's Strategic Plan include the recruitment of bicultural and bilingual staff, the development of additional IT systems to support outcomes of ICC services and collaboration with pediatric primary care providers and the sustainable implementation of additional evidence-based practices through several Intensive Learning Communities. To support these goals Eliot has created two new support positions; Quality Assurance Coordinator and Director of Evidence Based Practices and Clinical Training. Eliot's CBHI Leadership Team has worked diligently to ensure objectives are being managed and goals being met. All goals align with Eliot's mission of improving the quality of life for its engaged members.

C. Eliot's plans for improving timely access to ICC services

Eliot is constantly striving to ensure that each youth and family has timely access to services. Through this initiative Eliot intends to capitalize on the opportunity to secure additional resources in order to support several initiatives, including the need for a Community Integration and Outreach Coordinator which will enhance workforce development activities. This staff member is charged with connecting with non-traditional sources to recruit and expedite hiring of qualified candidates. A key deliverable during the first year of the grant will be to close the gap in Eliot's CSA staff vacancy rate and improve the retention of existing staff. Eliot will also review other factors that may be impacting access to care that are not staff vacancy driven including review length of service by program and objective measures and data currently being utilized to determine if leveraging existing community resources, affiliations and systems will enhance Eliot's ability to correspondingly serve more youth.

D. Eliot's plans for improving care coordination, care planning, and care management for ICC-Engaged Members

Eliot strongly believes that in order to respond to and meet the ever changing needs of the families and industry, continuous learning and quality improvement systems are crucial. From the onset of CBHI implementation Eliot committed to the Wraparound Principles. Currently, 100% of Eliot's ICCs and Family Partners hold Tier 1 Wraparound Certification, further strengthening its workforce, and supporting its commitment to improving services delivered using the Wraparound Principles as the foundation to the work. Always striving to build on its success and commitment to a continuous learning model, Eliot recently registered its CBHI Leadership Team for the 2017 National Wraparound Implementation Academy. At least one Eliot administrator will be attending one of the following modules, ensuring that information is shared and best practices are incorporated. The modules are as follows: Advancing Wraparound Practice for Care Coordination Supervisors; Strengthening Youth & Young Adult Engagement & Leadership; Enhancing Parent Peer-to-Peer Support & Leadership; Strengthening Evaluation, Research, & Outcomes Management and Advancing Organizational Executive Leadership Management. Through these modules, Eliot will implement those proven interventions and techniques, ensuring promising results for improving care coordination, planning and management for ICC engaged members.

E. Eliot's plans to improve performance on quality scores and Development Plan goals

Within this proposal Eliot has developed a comprehensive plan to address deficits as determined by the quality scores and Development Plan. The Agency is eager to continue to meet its goals of timely access and the creation and maintenance of a full complement of staff. These identified needs are connected, as without a stable and competent workforce timely access is compromised, and needs can be left unmet. Through this RFR Eliot intends to connect and collaborate with pediatric primary care providers and meet the goals of the RFR, through the addition of a Community Integration and Outreach Specialist that will focus on recruitment of staff, timely and seamless access of youth referred by pediatric PCP and a sustainable strategy for continued growth.

F. Eliot's plans for improving coordination with pediatric primary care and other physical and behavioral health care providers across the care continuum for youth

In a calendar year Eliot receives an average of 363 referrals for its CBHI services. Eight of those referrals, 2.2%, were from pediatric primary care physicians. Recognizing the important role PCPs serve not only from a medical perspective, but also a behavioral health lens, the Agency has chosen to address this issue within this RFR. Caretakers often utilize a child's physician as an assessor of needs, by bringing concerns related to symptoms of Serious Emotional Disturbance (SED) to the pediatrician. Eliot is excited to offer the enclosed proposal which will significantly increase its coordination with pediatric primary care providers.

Section 6.3 Populations Served and Community Engagement

A. Member populations, Communities served, promoting the health and wellbeing of individuals and actively initiating and maintaining engagement with individuals

The Malden Area CSA is the fourth largest in the state, providing Intensive Care Coordination with Family Support and Training services to a monthly average of 172 engaged youth in eight cities and towns in the Northeast. Towns and cities served by the CSA include Malden, Everett, Medford, Stoneham, Melrose, North Reading, Reading, and Wakefield. Eliot has the ability to meet the needs, and build on the strengths of diverse families and eclectic communities. The Eliot CSA employs a diverse team of bilingual and bicultural staff, reflective of the population served.

Understanding that in order to treat the many complex needs of the youth and families, a holistic approach must include a balance of all life's domains: educational, medical, recreational, spiritual, and mental health. When a youth is able to self-regulate, attach to positive caregivers and natural supports and experience competency in key skill areas he or she is more likely to experience sustained success. Eliot's ICC services ensure that all life domains are addressed, intensively coordinates services that meet each of those areas and, as the locus of the youth's care coordination, expects accountability from the youth, family and providers on tasks and assigned responsibilities.

Eliot seeks to have youth achieve success in all life domains including commitment to health, community and environment. Eliot has conducted workshops and events that encourage healthy relationships such as a youth-led workshop on consent and relationship violence, a cooking workshop with Whole Foods Market to support healthy and affordable family meals and Work Readiness Workshops to help youth build the skills needed to attain and maintain a job. Twice a year the popular Expression Show is held that allows youth the opportunity to showcase their talents, build self-confidence and support their peers.

In collaboration with the System of Care, Everett Youth Network, Malden Promise, local public schools and the SAMHSA funded, Healthy M.E. initiative, Eliot seeks to identity the individual needs of the youth in the community and provide supportive services to help meet those needs. From the very first contact, youth are encouraged to participate in every aspect of service delivery, advocate for their needs and to be active members of the community. At Eliot, youth are not only recipients of services, but active participants in their care planning teams, as well as, members of advisory boards that help to guide service provision. Youth are valued members of the Eliot team, his or her family and the entire community. Youth engagement is at the core of Eliot's behavioral health programming. Eliot believes that youth have a voice that should be heard. By promoting social and self-awareness, Eliot helps youth with behavioral health challenges to live to their potential, create positive outlooks for their futures and become active

participants in their community.

B. Relationships, collaborations and partnerships

The CSA serves as the "hub" for community collaborations through our work as host and chair of the Greater Malden System of Care (SOC). The SOC responds to the needs of families and system partners in the CSA catchment area. The SOC committee supports innovation in, and coordination of, community resources for children and families. The SOC committee is currently addressing issues that have been identified as barriers to current children's mental health policy and successful service implementation.

The SOC is currently involved in several community based projects and initiatives that support the vision and mission of the committee. For example, through an informal community needs assessment the Committee has identified that bullying is a critical issue relevant to the population served. In response, we have forged a relationship with the Boston vs Bullies program at the Sports Museum. In May, the SOC hosted Boston vs Bullies at Memorial Hall in Melrose for a parent training program.

The Eliot CSA is committed to the development of collaborations with our neighboring social services agencies, schools, medical providers, religious organizations, law enforcement and courts, after-school programs and youth centers. Eliot has forged relationships which have directly benefited its engaged members by providing them education in, and access to, services. The CSA has worked tirelessly to engage in projects, initiatives and events with agencies of likeminded missions and philosophies. These relationships have created the forum and platform for safety nets and natural supports and mitigated risk factors that could significantly impact sustained success.

Eliot's CSA Collaboration Chart is attached.

C. Alignment of partnerships with proposed projects

Eliot's CSA has developed deep roots in the communities served, and has fostered partnerships that will support continued innovation and collaboration in the interest of children, youth and families served. Eliot and numerous other human service agencies who use eHana, Eliot's Electronic Medical Health Record (EMR) are working together to enhance tools and interoperability to enhance existing systems which drive positive outcomes, reduce risk and increase communication of pertinent information.

Eliot has an established relationship with two recently selected ACO's, Cambridge Health Alliance Health Alliance and Children's Hospital Integrated Care Organization, both with Tufts Health Public Plan, and will work with each to guide the implementation of effective tools and

strategies to continually improve behavioral health services for children and families. Eliot will partner with these organizations to bring training to CSA staff to increase knowledge and understanding of healthcare systems, and "medical language".

Eliot understands the importance of overall physical, emotional and mental health for our children, youth and families. Pediatric primary care providers and centers are often the first point of contact for families when struggling with understanding their youth's behavior, physical or psychosomatic issues and possible mental health crises. Through this project Eliot will align with identified pediatric primary care practices to provide medical personnel and families the tools needed to screen for Serious Emotional Disturbances (SED), and connect quickly to appropriate care coordination and other behavioral health services.

Section 6.4 Proposed Projects and Investment Plan

A. Project Description

Eliot's proposal entitled **Eliot's Health Care Integration Project** addresses multiple needs while supporting the DSRIP program's objectives of providing innovative service delivery that promotes and enhances care coordination and integration. Currently, the majority of Eliot's referrals for ICC Services through Eliot's CSA come from the following groups: schools, hospitals, therapists in the community, and DCF. Although one of the first points of identifying behavioral health issues in children includes the pediatrician's office, Eliot historically does not receive a significant amount of referrals from this group.

During the preparation period and in year one the fully funded Community Integration Outreach Coordinator will focus on developing and fostering collaborative and reciprocal relationships with primary care pediatric practices, including smaller practices and ACO/MCO and other larger organizations throughout the CSA catchment area. This will include providing pediatric practitioners with screening, assessment and referral tools, and on-site support to offer real time assessment and intake for eligible individuals. In subsequent years, as collaborative relationships are firmly established, the role will take on additional responsibilities including billable intake coordination to support the salary with decreased DSRIP funds.

Eliot is committed to the continuous enhancement of service delivery through enhanced technology. As noted in Eliot's Behavioral Health Community Partner RFR, in collaboration with eHana, Eliot intends to invest substantially in the development of an innovative Care Management Platform and enhance linkages to the Mass HIway. Through DSRIP funds for CSA Infrastructure, Eliot, in collaboration with eHana, will develop and implement evidence based screening tools to assess youth for Serious Emotional Disturbances, determine eligibility for ICC services and link them to the CSA's Community Integration Outreach Coordinator for triaging and assignment of most appropriate service level. Additional funds will be allocated to collaborative projects with other eHana customers, including Wraparound/Strengths-Based Documentation, CANS Interoperability, Quality/Accountability Measures, System Security and Access Controls.

The targeted communities will include: Malden, Medford, Melrose, Everett, Stoneham, Wakefield, Reading and North Reading. Eliot's CSA will identify one pediatric group from each of the eight referenced towns. Designated criteria will include negotiating a successful referral affiliation agreement, historical data on referrals, and analysis of unmet need in the community.

*This section has been updated from the original submission to include additional details specific to the Project Prep Period

Eliot Community Human Services, Inc. ***July 7, 2017***

Infrastructure and Capacity Building Funding for Community Service Agencies

RFR Document #: 17LCEHSCHAICBRFR

The RFR program goals/investments that Eliot's grant proposal supports align with the goals of DSRIP funding and are as follows:

- Integration (Eliot CSA Services – Pediatric Care Organization [PCO]). Eliot, through affiliation agreements with PCOs and in conjunction with partnered ACOs and MCOs, will operationalize community based Primary Integration by deploying at PCO sites, evidenced based screening tools and improved access to CBHI services.
- Youth Mental Health First Aid (YMHFA) is a nationally recognized training tool for both administrative and front line staff. YMHFA goal is to increase awareness of common adolescent behavioral health challenges such as: anxiety, emotional and behavioral dysregulation and depression. Eliot has already trained both its front line and administrative staff on this nationally recognized best practice evaluation tool. Eliot's certified YMHFA trainers will provide YMHFA training to PCO staff with the goal of increasing awareness at the pediatrician's office of the warning signs in youth that may require further behavioral health screening and CBHI services.
- Electronic Medical Record- Eliot will provide training on the utilization of evidenced based screening tools to affiliated PCO staff, including improving referral procedures between pediatricians' offices and Eliot's CSA Services. Eliot currently uses eHana EHR for Care Management in our CSA program. Although it is anticipated that a new Care Management Platform will be developed, Eliot will be able to leverage the eHana EHR application as needed.
- Enhanced Technology-Eliot's IT department will provide supportive operational infrastructure including IT management and data storage. Eliot and eHana already have the capacity to query complete relational Care Management Platform datasets and expect to be able to meet any data reporting and interoperability requirements defined by EOHHS, ACOs and MCOs. Eliot anticipates working closely with ACO and MCO partners to determine mutually-agreeable datasets for information exchange with the goal of improving care coordination, management and implementation.
- Eliot intends to leverage standardized technology frameworks to facilitate data exchange with EOHHS, ACOs, MCOs, and other stakeholders including, Pediatric Care Organizations. eHana's Meaningful Use-certified EHR provides validated support for healthcare interoperability standards and standardized transaction formats.
- Eliot currently has a web only account to the Mass HIway. eHana plans to increase capacity to connect to the Mass HIway and expects that its use of the Mass HIway will greatly increase to include appropriate provider to provider communication, manual and automatic sharing of youth's information for the purpose of coordination of care. Eliot's Grant Objectives and Outcome Measures are attached.

*This section has been updated from the original submission to include additional details specific to the Project Prep Period

Prep Budget Period Project Focus

During the Prep Budget Period, as described in the updated budget and budget narrative, there are three sub-projects aligned with the over-arching project described above that will be addressed. Each project will have specific associated milestones and indicators for achievement.

1. *Training, Consultation, Recruitment and Retention Project*
   In order to ensure expeditious access to the highest quality services at the CSA for members, effective recruitment to ensure sufficient staffing capacity to accept cases quickly, enhanced professional development through collaborative training, and investment in long term staff retention are a priority through the prep period.
   Measures:
   a) *A Community Outreach and Integration Coordinator will be hired, trained and oriented by 1/31/18*
   b) *There will be an additional 4 ICC staff and 2 Family Partners hired, trained and oriented by 5/31/18.*
   c) *There are 20 Trained CSA workforce in Youth Mental Health First Aid and Enough Abuse by 5/31/18*
   d) *There will be approximately 50 ACO/PCO/MCO staff and/or affiliates trained in Youth Mental Health First Aid and/or Enough Abuse by Eliot Staff*
   e) *2 Staff Retreats focused on teambuilding and/or enhanced training will be held for CSA staff by 5/31/18*

2. *Community Outreach and Integration Project*
   With administrative guidance, support and oversight from the Project Lead and Director of Clinical Services, a newly developed position will focus on the development, enhancement, and maintenance of effective collaborations between the CSA and ACO/MCO/PCO entities, including expedited screening, eligibility determination and access to services.
   Measures:
   a) *A Community Outreach and Integration Coordinator will be hired, trained and oriented by 1/31/18*
   b) *Identify one ACO, MCO, or PCO site from each city/town in CSA catchment are by 3/31/18 to be evidenced by established contact*
   c) *Negotiate and execute MOU/Affiliation Agreement with the above selected ACO, MCO, PCO sites by 5/31/18*

3. *Software Development and Hardware Deployment Project*
   Efficient and effective technology is essential to the success to the over-arching DISRP

*This section has been updated from the original submission to include additional details specific to the Project Prep Period

funded project. Prep period investment in software development, in concert with Eliot's Community Partner initiatives, with ensure interoperability and secure data exchange. Deployment of enhance hardware technology will provide staff with the right tools to support enhanced software utilization in the field.

Measures:

a) *Purchase and install eHana software by 3/31/18 to be evidenced by a signed contract and specifications*
b) *Deploy enhanced hardware technology to CSA staff by 5/31/18 as evidenced by 8 clinicians effectively using the hardware to enhance productivity, communication, and member engagement in the community*

The updated CSA milestones report articulates specific indicators for achievement of the identified. In addition to these milestones, Eliot will utilize additional quality and outcome measures to track and evaluate project progress and impact. In addition to existing CSA-specific tools (TOMS and WIFI), Eliot has invested in Continuous Quality Improvement initiatives, which will support the evaluation of prep period projects. The Quality Assurance and Support Coordinator and Project lead will be responsible for the deployment of four standardized quality assurance and outcome surveys, beginning at the start of the prep period in January 2018 (to generate a baseline), and in June 2018 (to evaluate the impact of DISRP funded projects). The goal for improvement across these identified measures for the prep period is 10%. The surveys tools are as follows:

- Child/Youth Satisfaction Survey
- Caregiver/Guardian Satisfaction Survey
- Stakeholder/Referrer Satisfaction Survey
- Staff Satisfaction Survey

B. ***Project Team Description***

Eliot firmly believes that "it takes a village to raise a child". In support of this, the Project Team will be comprised of administrators and direct care staff from Eliot's CSA and Executive Staff Teams. The Project Lead will be Mederic McLaughlin, Regional Director of Wraparound Services for Eliot's Northeast Region. He will bring his extensive experience working in state government and hospital settings to the project, ensuring full compliance with financial, operational and reporting systems. The remainder of the Team will consist of Eliot's Chief Information Officer, Director of Community Based Services, Director of Clinical Services,

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Director of Family Support and Training, Director of the CSA, CBHI Intake Coordinator, Quality Assurance and Support Coordinator, Director of EBT and Clinical Training,' and Community Integration Outreach Coordinator.

Eliot's Youth Programming Organizational Chart, Project Organizational Chart, Project Management Team Duties and Responsibilities, Job Descriptions and Resumes are attached.

C. *Implementation Plan and Timeline*

Eliot's Implementation Plan and Timeline are attached.

D. *Budget Report and Budget Narrative*

Eliot's Budget Report and Budget Narrative are attached.

E. *Sustainability*

Eliot has committed to this project with the firm belief that coordination between ICC and FS&T services and pediatric primary care providers is critical to the physical, mental and behavioral health of the children and youth served by Eliot's CSA. Eliot not only believes that the project is sustainable for the involved practices, but will serve as a model for all pediatric care providers and practices, and CSAs, across the Commonwealth. Although the proposal speaks to five years, the Agency is confident that by meeting all the goals outlined in the project, its implementation will far exceed the targets.

Eliot is committed to partnering with ACOs, MCOs, PCOs, and EOHHS to achieve behavioral health integration between primary care pediatric providers and Eliot's CSA. Eliot possesses the capability, both operationally and through its continued investment in IT infrastructure, to ensure quick ramp up of CSA grant deliverables and continued sustainability beyond the grant period. Eliot will, with CSA grant funds, continue to develop additional IT capacity through enhancements to its EMR (eHana) improved connectivity and integration with Mass HIway, CANS interoperability, enhanced wraparound service documentation and fulfilling ACO, MCO, and EOHHS data requirements. The proposal uses key administrators from Eliot's expansive infrastructure, ensuring the project is fully supported by existing staff in position to make decisions, allocate resources and commit to a long-term plan. A crucial component of Eliot's plan for sustainability will be to develop allowable revenue enhancement billing protocols to support and sustain both the grant funded Community Integration and Outreach Coordinator position and increased CSA staffing. This will further support timely access to Eliot's services.

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Eliot expects that investments made in business startup and operational infrastructure will be fully absorbed within its existing operational budget and Eliot's administrative overhead budget, by the end of Year 5 of the grant and beyond.

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Section 6.4 Proposed Projects and Investment Plan

F. Project Description

Eliot's proposal entitled **Eliot's Health Care Integration Project** addresses multiple needs while supporting the DSRIP program's objectives of providing innovative service delivery that promotes and enhances care coordination and integration. Currently, the majority of Eliot's referrals for ICC Services through Eliot's CSA come from the following groups: schools, hospitals, therapists in the community, and DCF. Although one of the first points of identifying behavioral health issues in children includes the pediatrician's office, Eliot historically does not receive a significant amount of referrals from this group.

During the preparation period and in year one the fully funded Community Integration Outreach Coordinator will focus on developing and fostering collaborative and reciprocal relationships with primary care pediatric practices, including smaller practices and ACO/MCO and other larger organizations throughout the CSA catchment area. This will include providing pediatric practitioners with screening, assessment and referral tools, and on-site support to offer real time assessment and intake for eligible individuals. In subsequent years, as collaborative relationships are firmly established, the role will take on additional responsibilities including billable intake coordination to support the salary with decreased DSRIP funds.

Eliot is committed to the continuous enhancement of service delivery through enhanced technology. As noted in Eliot's Behavioral Health Community Partner RFR, in collaboration with eHana, Eliot intends to invest substantially in the development of an innovative Care Management Platform and enhance linkages to the Mass HIway. Through DSRIP funds for CSA Infrastructure, Eliot, in collaboration with eHana, will develop and implement evidence based screening tools to assess youth for Serious Emotional Disturbances, determine eligibility for ICC services and link them to the CSA's Community Integration Outreach Coordinator for triaging and assignment of most appropriate service level. Additional funds will be allocated to collaborative projects with other eHana customers, including Wraparound/Strengths-Based Documentation, CANS Interoperability, Quality/Accountability Measures, System Security and Access Controls.

The targeted communities will include: Malden, Medford, Melrose, Everett, Stoneham, Wakefield, Reading and North Reading. Eliot's CSA will identify one pediatric group from each of the eight referenced towns. Designated criteria will include negotiating a successful referral affiliation agreement, historical data on referrals, and analysis of unmet need in the community.

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Eliot Community Human Services, Inc. ***July 7, 2017***

Infrastructure and Capacity Building Funding for Community Service Agencies

RFR Document #: 17LCEHSCHAICBRFR

The RFR program goals/investments that Eliot's grant proposal supports align with the goals of DSRIP funding and are as follows:

- Integration (Eliot CSA Services – Pediatric Care Organization [PCO]). Eliot, through affiliation agreements with PCOs and in conjunction with partnered ACOs and MCOs, will operationalize community based Primary Integration by deploying at PCO sites, evidenced based screening tools and improved access to CBHI services.
- Youth Mental Health First Aid (YMHFA) is a nationally recognized training tool for both administrative and front line staff. YMHFA goal is to increase awareness of common adolescent behavioral health challenges such as: anxiety, emotional and behavioral dysregulation and depression. Eliot has already trained both its front line and administrative staff on this nationally recognized best practice evaluation tool. Eliot's certified YMHFA trainers will provide YMHFA training to PCO staff with the goal of increasing awareness at the pediatrician's office of the warning signs in youth that may require further behavioral health screening and CBHI services.
- Electronic Medical Record- Eliot will provide training on the utilization of evidenced based screening tools to affiliated PCO staff, including improving referral procedures between pediatricians' offices and Eliot's CSA Services. Eliot currently uses eHana EHR for Care Management in our CSA program. Although it is anticipated that a new Care Management Platform will be developed, Eliot will be able to leverage the eHana EHR application as needed.
- Enhanced Technology-Eliot's IT department will provide supportive operational infrastructure including IT management and data storage. Eliot and eHana already have the capacity to query complete relational Care Management Platform datasets and expect to be able to meet any data reporting and interoperability requirements defined by EOHHS, ACOs and MCOs. Eliot anticipates working closely with ACO and MCO partners to determine mutually-agreeable datasets for information exchange with the goal of improving care coordination, management and implementation.
- Eliot intends to leverage standardized technology frameworks to facilitate data exchange with EOHHS, ACOs, MCOs, and other stakeholders including, Pediatric Care Organizations. eHana's Meaningful Use-certified EHR provides validated support for healthcare interoperability standards and standardized transaction formats.
- Eliot currently has a web only account to the Mass HIway. eHana plans to increase capacity to connect to the Mass HIway and expects that its use of the Mass HIway will greatly increase to include appropriate provider to provider communication, manual and automatic sharing of youth's information for the purpose of coordination of care. Eliot's Grant Objectives and Outcome Measures are attached.

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Prep Budget Period Project Focus

During the Prep Budget Period, as described in the updated budget and budget narrative, there are three sub-projects aligned with the over-arching project described above that will be addressed. Each project will have specific associated milestones and indicators for achievement.

4. *Training, Consultation, Recruitment and Retention Project*
   In order to ensure expeditious access to the highest quality services at the CSA for members, effective recruitment to ensure sufficient staffing capacity to accept cases quickly, enhanced professional development through collaborative training, and investment in long term staff retention are a priority through the prep period.
   Measures:
   - *f) A Community Outreach and Integration Coordinator will be hired, trained and oriented by 1/31/18*
   - *g) There will be an additional 4 ICC staff and 2 Family Partners hired, trained and oriented by 5/31/18.*
   - *h) There are 20 Trained CSA workforce in Youth Mental Health First Aid and Enough Abuse by 5/31/18*
   - *i) There will be approximately 50 ACO/PCO/MCO staff and/or affiliates trained in Youth Mental Health First Aid and/or Enough Abuse by Eliot Staff*
   - *j) 2 Staff Retreats focused on teambuilding and/or enhanced training will be held for CSA staff by 5/31/18*

5. *Community Outreach and Integration Project*
   With administrative guidance, support and oversight from the Project Lead and Director of Clinical Services, a newly developed position will focus on the development, enhancement, and maintenance of effective collaborations between the CSA and ACO/MCO/PCO entities, including expedited screening, eligibility determination and access to services.
   Measures:
   - *d) A Community Outreach and Integration Coordinator will be hired, trained and oriented by 1/31/18*
   - *e) Identify one ACO, MCO, or PCO site from each city/town in CSA catchment are by 3/31/18 to be evidenced by established contact*
   - *f) Negotiate and execute MOU/Affiliation Agreement with the above selected ACO, MCO, PCO sites by 5/31/18*

6. *Software Development and Hardware Deployment Project*
   Efficient and effective technology is essential to the success to the over-arching DISRP

funded project. Prep period investment in software development, in concert with Eliot's Community Partner initiatives, with ensure interoperability and secure data exchange. Deployment of enhance hardware technology will provide staff with the right tools to support enhanced software utilization in the field.

Measures:

c) *Purchase and install eHana software by 3/31/18 to be evidenced by a signed contract and specifications*

d) *Deploy enhanced hardware technology to CSA staff by 5/31/18 as evidenced by 8 clinicians effectively using the hardware to enhance productivity, communication, and member engagement in the community*

The updated CSA milestones report articulates specific indicators for achievement of the identified. In addition to these milestones, Eliot will utilize additional quality and outcome measures to track and evaluate project progress and impact. In addition to existing CSA-specific tools (TOMS and WIFI), Eliot has invested in Continuous Quality Improvement initiatives, which will support the evaluation of prep period projects. The Quality Assurance and Support Coordinator and Project lead will be responsible for the deployment of four standardized quality assurance and outcome surveys, beginning at the start of the prep period in January 2018 (to generate a baseline), and in June 2018 (to evaluate the impact of DISRP funded projects). The goal for improvement across these identified measures for the prep period is 10%. The surveys tools are as follows:

- Child/Youth Satisfaction Survey
- Caregiver/Guardian Satisfaction Survey
- Stakeholder/Referrer Satisfaction Survey
- Staff Satisfaction Survey

G. ***Project Team Description***

Eliot firmly believes that "it takes a village to raise a child". In support of this, the Project Team will be comprised of administrators and direct care staff from Eliot's CSA and Executive Staff Teams. The Project Lead will be Mederic McLaughlin, Regional Director of Wraparound Services for Eliot's Northeast Region. He will bring his extensive experience working in state government and hospital settings to the project, ensuring full compliance with financial, operational and reporting systems. The remainder of the Team will consist of Eliot's Chief Information Officer, Director of Community Based Services, Director of Clinical Services,

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CSA Budget Report

Family Service Association of Greater Fall River (FSA)

Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites	1	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate	NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)	203	203	203	203	203	203	
Estimated Funds	$ 125,772.00	$ 142,100	$ 85,260	$ 60,900	$ 53,592	$ 24,360	**$ 366,212**
At- Risk Withhold Rate			5%	10%	15%	20%	
Withhold			$ 4,263	$ 6,090	$ 8,039	$ 4,872	**$ 23,264**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 125,772.00	$ 142,100	$ 80,997	$ 54,810	$ 45,553	$ 19,488	**$ 468,720.20**

Investment Projects	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Project 1 Name: Technology Advancement: Development/Adaptation of EHR							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ 19,928	$ 61,916	$ 42,875	$ 28,469	$ 28,775	$ 11,834	**$ 193,796**
Development Adaptation of EHR and/or Care Management System	$ 59,100	$ -	$ -	$ -	$ -	$ -	**$ 59,100**
Technology for Service Delivery	$ 6,000	$ 29,450	$ 5,000	$ 5,000	$ -	$ 5,000	**$ 50,450**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ 2,400	$ -	$ -	$ -	$ -	$ -	**$ 2,400**
Retention Expenses	$ 1,000	$ -	$ -	$ -	$ -	$ -	**$ 1,000**
Operational Infrastructure							
Operation Staffing including Fringe	$ 14,385	$ -	$ -	$ -	$ -	$ -	**$ 14,385**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 1 Total	$ 102,813	$ 91,366	$ 47,875	$ 33,469	$ 28,775	$ 16,834	**$ 321,131**
Project 2 Name: *Workforce Development*							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ 450	$ -	$ 500	$ 500	$ 250	**$ 1,700**
Training Expenses	$ -	$ 14,500	$ 19,900	$ 13,991	$ 7,072	$ -	**$ 55,463**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure							
Operation Staffing including Fringe	$ 6,509	$ 10,057	$ -	$ -	$ -	$ -	**$ 16,566**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 2 Total	$ 6,509	$ 25,007	$ 19,900	$ 14,491	$ 7,572	$ 250	**$ 73,729**
Project 3 Name: *[Project title here]*							
DSRIP Goal(s) Addressed: Goal 1:	*Required*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 3 Total	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 4 Name: *[Project title here]*							
DSRIP Goal(s) Addressed: Goal 1:	*Required*						
Goal 2:	*Optional*						

	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 4 Total		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 5 Name: *[Project title here]*								
DSRIP Goal(s) Addressed:	Goal 1:	*Required*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 5 Total		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 6 Name: *[Project title here]*								
DSRIP Goal(s) Addressed:	Goal 1:	*Required*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 6 Total		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 7 Name: *[Project title here]*								
DSRIP Goal(s) Addressed:	Goal 1:	*Required*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 7 Total		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Project Costs		$ 109,322	$ 116,373	$ 67,775	$ 47,960	$ 36,347	$ 17,084	$ **394,861**
Indirect Costs/ Administrative Overhead Rate	15%	$ 16,398	$ 17,456	$ 10,166	$ 7,194	$ 5,452	$ 2,563	$ **59,229**
Investment Projects Total		$ 125,720	$ 133,829	$ 77,942	$ 55,154	$ 41,799	$ 19,647	$ **454,090**

BH
Community Partners

4. PBP Infrastructure Budget Narrative

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name: Technology Advancement: Development/Adaptation of EHR

DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-En*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
IT Manager	$ 62,662.60	0.3	5	$ 7,833
SQL Report Writer	$ 42,848.00	0.4	5	$ 7,141
IT Assistant	$ 41,808.00	0.06	5	$ 1,045
				$ -
				$ -
				$ -
	Total Salary	0.76		$ 16,019
	Fringe rate	24.4%	Total Fringe	$ 3,909
			Total IT Staffing including Fringe	**$ 19,928**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

IT Manager will be responsible for collaborating with consultants to provide oversight of the implementation plan. The IT Manager will serve as chairperson for Implementation Team meetings and participate in comprehensive individualized training on the development, testing and deployment of configurable forms and specialized report writing.

SQL Report Writer will assist in developing configurable forms and write reports needed to ensure quality metrics are readily accessed.

IT Assistant will perfrom hardware and user configuration, and technical support to users as needed.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
IT Consultants	$ 22,500.00
ITConsultant/Programmers	$ 23,100.00
Qualifact Project Manager	$ 9,000.00
Qualifacts Consultant	$ 4,500.00
Total Development and Adaptation of EHR and Care Management System	$ 59,100.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

The goal of this project is to create a fully functioning, comprehensive electronic health record that will provide consistent

and timely reporting and support achievement of quality measures. The EHR will support secure communication with other providers and full functionality with the Mass HIway. Furthermore, the EHR will support integration of care, care planning and care coordination by being fully accessible to all registered users from any community location, putting the electronic health record at the worker's fingertips whenever and wherever it is needed.

IT Consultants/ will analyze current paper process, develop electronic workflow and work collaboratively with internal FSA resources. 150 hours @ $150/hr. **Total: $22,500.00**

IT Consultants/Programmers to draft EHR configurable forms, test and edit drafts and implement final versions of all forms required to support CSA services. 154 hours @ $150/hr. **Total: $23,100.00**

Qualifacts Project Manager: Responsible for designing EHR Implementation Plan and overseeing initial phase of project implementation. 60 hours @ $150.00 per hour (2 day kickoff session, then 2 hrs/wk for 22 weeks.) includes estimated expenses. **Total: $9,000.00**

Qualifacts Consultants: Responsible for creating specialized reports and complex configurable forms to support comprehensive data collection and seamless customization of EHR. 30 hours @ $150.00/hr. **Total: $4,500.00**

Technology for Service Delivery

Description of Expense	Cost
Hardware	$ 6,000.00
Total Technology for Service Delivery	**$ 6,000.00**

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Hardware Investments: Provide all ICC's with updated laptops, which will improve program's ability to be mobile allow real time to access EHR, improve documentation standards, and support compliance. 10 laptops @ $600.00 each. **Total: $ 6,000.00**

Other Technology Expenses

Description of Expense	Cost

Total Other Technology Expenses	**$ -**

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS March 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
					Technology	IT Staffing including Fringe								
Project 1	Technology Advancement: Development/Adaptation of EHR	Implement Electronic Health Record	01/01/18	12/31/19	**Technology**	Development Adaptation of EHR and/or Care Management System	Electronic Care Plan is established and tested	Draft Care Plan will be completed and tested with at least one program staff.						
Project 1	Technology Advancement: Development/Adaptation of EHR	Improve access to information to support wrap-around services	01/01/18	12/31/22	**Technology**	Technology for Service Delivery	All employees have remote acces to EHR	Invoices will confirm that program employees will be issued new laptops						
					Technology	Other Technology Expenses								
					Workforce Development	Workforce Development staffing including Fringe								
					Workforce Development	Recruitment Expenses								
					Workforce Development	Training Expenses								
					Workforce Development	Retention Expenses								
					Operational Infrastructure	Operation Staffing including Fringe								
					Operational Infrastructure	Other Operational Expenses								
Project 2	Workforce Development	Create curriculum to provide additional training to increase the fidelity of the Wraparound model	01/01/18	08/01/18	**Operational Infrastructure**	Training Expenses	FSA's Wraparound Tier 1 credentialing curriculum will be completed.	FSA's Wraparound Tier 1 credentilalaing curriculum						
					Operational Infrastructure									

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INFRASTUCTURE AND CAPACITY BUILDING FUNDING FOR COMMUNITY SERVICE AGENCIES

ISSUED: MAY 26, 2017

RFR DOCUMENT #:17LCEHSCSAICBRFR

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SECTION 6.2 EXECUTIVE SUMMARY

Family Service Association (FSA) understands the State's DSRIP program and goals and enthusiastically responds to this Request for Responses (RFR). Our proposed projects support the goals described in the RFR. We are confident our organization has the experience, resources and capacity to succeed in supporting the state's DSRIP goals and delivering effective Community Service Agency (CSA) services.

6.2 A. Performance on Development Plan: Our CSA is a well-established, high performing program that operates with a solid knowledge of the performance specifications. Historically, FSA has met or exceeded the performance threshold on all domains; and the program continues to evolve and improve in response to feedback. Development plans have been well-received by the program's leadership and progress has consistently been made.

In January of 2017 two new goals were established. The first goal was to increase the effectiveness of the team process for CSA enrolled families. Due to attrition within provider agencies, FSA was experiencing an increase in the number of team members working with CSA families who had little to no working knowledge of the principles of Wraparound. The need for additional education about Wraparound and more intensive efforts toward team building became apparent. In response, the CSA is using the following interventions:

- Group and individual coaching to focus on effective team process
- Wraparound orientation for team members
- Application of best practices to build and maintain effective teams
- Documenting team building and team process
- Communicating the value of team attendance to persons served, and
- Highlighting the important role of tem member participation during the care planning process

Progress towards this goal will be measured using the TOMS, WFI and care plan review and approval by Senior Care Coordinators (SCC). Group coaching for CSA staff was completed in March. SCCs will continue to review and assist staff to overcome barriers to best practice. Internal clinical reviews, de-briefings, group coaching and supervision will remain focused on best practices for building and sustaining effective teams for CSA enrolled families.

A second goal was to include a Mental Status Examination (MSE) in all ICC assessments conducted on enrolled youth. This goal has been met by including the MSE in the standardized assessment. The assessment is reviewed and signed by a SCC who is also an independently licensed Masters-level behavioral health clinician. Internal record review processes ensure this requirement is consistently implemented. In addition, FSA provides record review through a peer review process that includes evaluation of the assessment and evidence of SCC review and signature. This two phase review process ensures that the changes made to the assessment to include the MSE are consistently implemented.

6.2 B Strengths and Needs: The CSA has many strengths. The first is strong leadership provided by an independently licensed Masters-level clinician with extensive clinical experience. This Leader is further supported by two additional independently licensed clinicians who serve as SCCs. This strong leadership team facilitates formulation of a behavioral health diagnosis (when needed), and provides clinical supervision to the ICCs. Another strength is the internal multi-disciplinary team that has been formed. This strong clinical approach ensures the diagnosis takes center stage and that Wraparound services are clinically informed. Another strength is that the CSA staff includes three credentialed Wraparound coaches from the original cohort trained by Vroon VanDenBerg when CSAs were first formed across the state. This strong knowledge base in the principles of Wraparound ensures that as new staff are hired, they too can be well informed and prepared to serve their role in this strength-based model. The CSA also has a strong

language capacity to provide culturally and linguistically responsive services, mirroring the community we serve. Currently the program employs five Spanish-speaking ICCs and four Spanish-speaking Family Partners (FP). In addition to Spanish language capacity, the program employs one Portuguese-speaking ICC, one Khmer-speaking ICC, two Portuguese-speaking FPs and one Creole speaking FP. The CSA has worked very hard at maintaining language capacity and ensuring responsiveness to referral trends. The CSA has never had a development plan for access to CSA services. The FSA CSA has a strong team comprised of flexible, cooperative and collaborative staff and even in times of intense referral rates the CSA has consistently met performance standards for offering an initial appointment. The CSA has also added an Intake Coordinator position to support responsiveness to referrals.

The strength of the CSA can be seen in the staff. From the extensive clinical experience to the language capacity and solid knowledge and implementation of Wraparound, what makes the CSA great is the people we employ. But, that can quickly become a need for the program. At the time of this application, the program is fully staffed with extensive language capacity and many tenured employees that include credentialed Wraparound coaches. In order for the CSA to remain responsive to community demands, staff retention needs to be a high priority. Also, a pool of qualified candidates needs to be available to fill positions as they are vacated or when a new position is added. When new staff are hired, there is a significant learning curve which takes time for training and coaching. Ensuring FSA has the capacity to quickly respond to staffing needs with timely turnaround from vacancy to filled position is essential.

Another need within the CSA lies in technology. Currently the CSA only has digital capacity for progress notes. To maximize efficiency, the program needs a fully functional and integrated Electronic Health Record (EHR). The program also needs to strengthen its capacity to gather, analyze and respond to data. Currently, the program has short term and anecdotal data and operations are more reactive than proactive. With stronger technology, the program will be better equipped to evaluate outputs and outcomes and take a more proactive approach to program management and development. Expanded digital capacity will also support better communication, coordination and integration of care.

Finally, the program has a need for more training specific to CSA, the role of ICCs and FPs and community-based interventions. Program staff recently participated in a six-hour workforce development workshop on trauma-informed care. While useful, the program focused on direct work with trauma victims and site-based work. Further training is needed specific to community-based work and how to facilitate recovery for trauma victims when not treating the trauma directly. A better understanding of medical and psychiatric conditions is also needed with an emphasis on how diagnosis may impact behavior.

6.2 C Plans for Improving Timely Access to ICC Services: From the start of CSA service provision, the FSA program has excelled in providing timely access. This has been the direct result of efficient, effective and responsive recruitment and hiring, training and coaching, and attention to referral rates and trends. The strong clinical background of the leadership team helps to ensure caseload assignments are realistic and reasonable in relation to the presenting needs of the family. From the outset, the CSA experienced a referral rate that was much more intense than originally predicted. Armed with that experience, the CSA is now favorably positioned to respond to changes in referral rates related to the DSRIP program and to improve integration across different settings of care.

FSA plans to further improve access to ICC services by supporting the recently added position of Intake Coordinator. The Intake Coordinator manages all referrals; maintains referral logs, triages referrals and

consults with program Leadership for staff assignments. She also does initial screening for medical necessity criteria and home safety, maintains communication with referral sources on the status of the referral and provides parents/caretakers with information on program services. This ensures a consistent referral-screening-intake experience for every family and referral source. The CSA has never had a waitlist for referrals and maintaining these proven effective strategies will help to ensure we maintain that level of success. In the event the CSA experiences a dramatic increase in referrals, FSA will evaluate the need for additional support services. To further support timely access to services, FSA will apply investment funds to accelerate the Human Resource Department's capacity to recruit and hire in a timely manner.

6.2 D Plans for Improving Care Coordination, Care Planning and Care Management for ICC-Engaged Members: FSA believes the most important step to improving care coordination, care planning and case management is to ensure staff have the knowledge and skills needed to effectively implement Wraparound and build an effective team. In support of this philosophy, FSA will create a structured Workforce Development Plan. The Plan will recognize training and proficiency on related skills, offering staff an opportunity to advance their skill set within the program. FSA is fortunate to have many staff that started with the CSA and have achieved five years in the program. A Workforce Development Plan offers an incentive to continually work at proficiency as a way to retain experienced workers. It also builds a pool of talent to help educate, coach and mentor new staff as they enter the program. The Workforce Development Plan will make use of the Tier 1 and Tier 2 Wraparound credentialing in the early years of funding, making credentialing available to all staff. In future years, the Workforce Development Plan will evolve to include credentialing/certification in other critical areas such collaborative problem solving, motivational interviewing and integration/coordination of care. Only evidence-based models will be used for the Workforce Development Plan and it will be built on achieving established benchmarks and concrete measures to confirm skill development and proficiency.

6.2 E Plans to Improve Performance on Quality Scores and Development Plan Goals: The CSA will use advancements in technology to support improved performance on quality scores and to meet development plan goals. The current EHR in use in FSA is fully customizable. That allows FSA to build service documents that include modules with required fields. In short, we can make the desired action the default action. We can also customize the EHR to gather the data points that will support monitoring progress towards performance goals, both for the program as a whole and by individual practitioner. The system will also create reminders to track key activities and alerts for SCCs to monitor performance. In addition workforce development on Wraparound, building effective teams, collaborative problem-solving and motivational interviewing will help support achievement of performance measures.

6.2 F Plans for Improving Coordination with Providers Across the Continuum: FSA intends to apply the advances made through the technology project that is part of this application to improve coordination with providers across the continuum. FSA plans to expand our digital capacity, using telecommunications to promote health and integration of care. The addition of mobile resources will allow providers to share information in real time and to participate in care plan meetings. FSA will also continue to be an active participate on the Southcoast interagency team, a collaborative of CSAs and state agencies, to promote coordination of care. FSA will leverage the success of the current Systems of Care committee to welcome new providers and build relationships to facilitate care coordination. FSA will also apply lessons learned from current work with the Steward Health Care Network on pilot ACO projects to improve coordination with other providers.

SECTION 6.3 POPULATION SERVED AND COMMUNITY ENGAGEMENT

6.3 A. Member Population and Communities: The Community Service Agency (CSA) serves families who have a child/children with mental health needs; or youth with developmental disorders with co-occurring mental health needs. The program serves children up to the day of the 21st birthday. The geographic region served is Greater Fall River, which includes Fall River, Westport, Swansea, Somerset, Westport and Freetown. Family choice is an honored principle in Wraparound services and thus, FSA serves children/families in other geographic locations when it is the family choice to have FSA as the provider. FSA has served families in New Bedford, Seekonk, Taunton, Raynham and Dartmouth. Over the past year, the population served has been 63% male and 37% female. The primary language spoken has been English, with 24% speaking Spanish and 5% speaking other languages including Portuguese, Khmer and French. The largest age group served is 10-14 year olds at 45%, followed by 5-9 year olds at 34% and15-19 year olds at 17%. The racial/ethnic composition of youth served is 50% white, 10% Black/African American, 31% Hispanic/Latino and 8% multi-racial. The majority did not affiliate with any specific religion.

FSA plans to promote the health and well-being of the diverse group of youth and families served through a holistic and comprehensive approach. The program aims to strengthen the family by strengthening parental capacity. This is achieved through Family Partner (FP) services. Interventions for parents include education, modeling, mentoring and coaching to build skills to better manage not only the parent's health and well-being, but that of the family as well. CSA staff recognize that parents need to be strong and healthy themselves to parent effectively. Parents also need to be engaged in order for services to be effective.

The CSA uses a number of engagement strategies. Program staff are vigilant with weekly contacts by the ICCs as well as the FP. There is consistent follow-up for missed calls and appointments. Staff work to "meet parents where they are" in the process. ICCs and FPs help to identify and define challenges and obstacles; and work with families to prioritize needs based on criticality. For example, when a family is experiencing housing insecurity or homelessness, that must be resolved before behavior management or truancy can be addressed. Once priorities are established, parents can develop a clearer view of what's in front of them and what needs to be done. To be effective with any of these activities, ICCs and FPs establish mutually respectful relationships that are built on trust. ICCs and FPs respond to calls, follow-through with actions, and are responsive to families. They are truthful and realistic in their work with parents. In short, they are clear on what they can and cannot d; and they do what they say they are going to do when they say they are going to do it. This helps to build trust with families and instill confidence; key elements to fostering and sustaining engagement.

Another strong factor in fostering and maintaining engagement is fidelity to the ten principles of Wraparound. This includes family voice and choice. Care planning and service coordination is built upon the family's perceived priorities and not the worker's. The CSA builds and utilizes a team of providers that constitute an individualized system of care for each family. Together, families and CSA staff identify resources that will support achievement of goals and then staff facilitate and support families to access what they need in order to succeed. Fidelity to the strength-based principle also promotes success. A thorough assessment identifies where the parent/child/family are or have been strong and successful in the past. They then leverage identified strengths and achievements to address current challenges. As families achieve additional successes, they begin to build the confidence to achieve and sustain future success.

To support the future success of the CSA, FSA will dedicate capacity funding to expanding our technological capacity and to workforce development. By advancing technology we can promote mobile,

community-based services and facilitating access to real-time information. Putting contemporary digital tools in the hands of our talented and dedicated staff will support communication, promote coordination of care and advance integration. Ongoing education, support and coaching, will support fidelity to the model which has proven successful thus far. Resources will also be allocated to expand staff knowledge of medical and behavioral health diagnoses that impact family functioning. The better equipped, informed and educated the staff are, the better the more effective they will be at promoting health and well-being.

6.3 B. Community Relationships: FSA enjoys a strong community reputation and has cultivated meaningful partnerships and collaborations in support of our mission to build individual and family strengths. One example is the Southcoast Interagency Team with the Department of Children and Families, the Department of Mental Health, the Department of Developmental Services and the Department of Youth Services. Regular meetings of this team have supported relationship building on the organizational and personal level. It has provided education, a forum to identify and communicate challenges, a place for the provider voice to be heard and a means to identify service gaps and address access to care concerns. The CSA's strong Systems of Care Committee (SOC) is another valuable relationship. The SOC has a favorable reputation in the community and has helped to build strong bonds with other providers. FSA hosts monthly meetings which have become a forum to exchange ideas and introduce new providers and practitioners. Representatives from various providers share access challenges and service availability. When the CSA has faced challenges in meeting quality measures, the SOC has also been a productive forum to problem-solve and brainstorm interventions.

The CSA has solid relationships with other CBHI providers in the region; including In-Home Therapy, Therapeutic Mentoring, Mobile Crisis Intervention and In-Home Behavioral Therapy. Two of FSA's strongest allies are Child and Family Services and St. Vincent's. Working together with other CBHI providers allows FSA to find the organization/provider that is the best fit for the family. Other providers with whom FSA has strong collaborations are Arbor Counseling Services, the Institute for Health and Recovery, the Castle Program and the Family Nurturing Center. These organizations support and promote the CSA through service provision, collaborative work with children/families and as resources for staff development.

For integration and coordination of care and services, the CSA enjoys productive and collaborative relationships with all of the area pediatric practices. We work frequently with the Boys and Girls Club and the YMCA to connect youth to the community. The partnership between FSA and Greater Fall River Re-Creation has resulted in scholarships for youth/families and Re-Creation's outreach program for gang involved youth has supported families facing this challenge. The CSA also works well with the Fall River Police Department. Through this collaboration we have ensured worker and community safety in high risk neighborhoods. We have also increased police understanding of the needs of involved youth. When police intervention is needed in a crisis, they recognize the role of the CSA. They listen to worker's input and together we have made police intervention less confrontational and more effective.

The CSA Leadership is part of an organizational team that includes the Leaders of the other FSA services. This promotes timely access to services to support engaged youth and families. Whether it be child care, services for aged or chronically disabled adults or mentorship, the vast array of FSA services are available to CSA families. The FSA Family Resource Center has also evolved into an important support for CSA families, offering evidence-based parenting education programs, support groups and recreational activities.

Finally, FSA has, for the past three years, cultivated a partnership with the Steward Health Care Network (SHCN). Through a series of projects, FSA and SHCN have explored the concept of shared governance and data sharing from both the technology and service delivery perspectives. Currently, SHCN and FSA are working on an Emergency Department Case Management project to explore and address avoidable use of Emergency Departments and drivers of total cost of care. This preliminary work with SHCN lays the foundation for meaningful work with SHCN as one of the ACOs for Greater Fall River. An old proverb says "*it takes a village to raise a child".* FSA is proud to be part of a talented and dedicated village of child-serving providers and organizations working together to promote the health of our community's children.

6.3 C. Aligning Partnerships in Support of Capacity Funded Projects: FSA is proposing two projects to advance the aims of the DSRIP program; Technology Advancement and Workforce Development. The Technology Advancement project will expand the CSA's capacity to serve families by promoting mobility and the effective delivery of services; facilitating access to digital data and resources while working in the community. Technology Advancement will promote care management and coordination within the CSA, FSA and with identified partners through a fully operational EHR. It will also promote mobile digital communication. The better our capacity to securely share data, the more timely, efficient and effective we can be. It is our goal to ultimately be equipped to offer providers and distant family members a virtual seat at the table, even if physical presence at meetings and consultations is not possible. FSA will also aim to improve integrated health and pursue the capacity for telemedicine with participating providers. Expanded mobile and digital capacity will also foster stronger connections with partners, schools and primary care providers. These cost effective, contemporary advancements will expand options for children and families.

Through the Workforce Development project, FSA strives to strengthen and sustain fidelity to Wraparound processes. This includes not only the ten principles of Wraparound but also care planning, care management and care coordination. FSA will rely upon feedback from community partners to inform and guide educational initiatives. For example, FSA will promote Tier 1 and Tier 2 Wraparound certification for ICCs and FPs. While the curriculum and proficiency thresholds for certification are established, FSA will emphasize areas where a development need has been identified based on feedback, identified gaps and challenges related to the delivery of CSA services. The building of strong teams is currently a focus within the CSA and is achievable because of the existing partnerships that lay the groundwork for further advancements. Findings from TOMS and WFI will also help to guide educational interventions. We will also regularly seek feedback from community partners via anonymous surveys to measure our effectiveness in executing Wraparound processes.

The CSA works collaboratively with the other CSAs in the Southeast region. Directors communicate regularly, share insights and strategize responses to challenges. FSA will align this partnership in support of capacity funded projects by working together to apply resources for regional training. FSA's proposed Workforce Development Plan will include the shared training coordinated among the participating providers. Together the Southeast region CSAs have identified key clinical areas in which to develop an evidence-based training program for ICCs that will build and maintain skills while also facilitating improved outcomes for the programs. The identified areas include Motivational Interviewing; Diagnostic Formulation and Treatment Planning, Collaborative Problem Solving; ARC, Coordination of Care for Medically Complex Youth, and Wraparound Certification. Each CSA will contribute to the development of the training content. Collectively, every CSA in the Southeast region will benefit from the efforts and families served will benefit from a more informed team delivering CSA services.

6.4 A. Project Description and 6.4 B Project Team Description: Family Service Association (FSA) proposes a two-pronged approach to infrastructure and capacity building to aid in advancing the goals of the state's DSRIP program within our organization. The first arm of the plan is a technology advancement strategy and the second arm is a workforce development initiative. Both aspects of this bifurcated approach are aimed at putting the tools needed to deliver effective services in the hands of the staff working face-to-face with youth and families. Access to efficient and contemporary technology is the first important step. To that end, it is FSA's intent to expand our digital and technological capacity to foster community outreach, promote strong integration with ACOs, MCOs and primary care providers and facilitate timely access to ICC services. The second important step in giving staff the tools they need to get the job done includes training, coaching and modeling. Through this initiative we can strengthen fidelity to Wraparound processes, including care planning, care management and care coordination. To remain a viable provider, FSA needs to ensure we have a readily available pool of skilled practitioners who are prepared to respond to referrals and deliver Wraparound services. To achieve this we must retain our talented and dedicated staff by ensuring the roles of Intensive Care Coordination (ICC) and Family Partner (FP) are challenging and rewarding. The workforce development strategy we propose will support this goal. Details of each of the two projects follows.

Project One - Technology Advancement: The first goal of this project is to create a fully functioning electronic health record (EHR). This will allow secure and timely access to client level information to ease the delivery of ICC services. It will also support improved coordination of care and strong integration with ACOs and primary care providers. FSA already has an EHR, Qualifacts Carelogic; but, it is only minimally implemented in the CSA program. Carelogic is specifically designed for behavioral health centers and human service providers and it allows for complete customization. Currently, the CSA programs uses Carelogic for progress notes and billing. This results in a hybrid client record with information in multiple formats and locations, and requires substantial manual work to ensure good communication to providers. In order to best support the Wraparound process, the full implementation of the EHR for CSA will include:

- Customization to ensure strong workflow processes
- A singular comprehensive client record
- Secure information sharing with other providers
- Accurate, seamless and consistent reporting

Successful implementation will be completed in two phases over the five year period. The first phase will be a partial implementation, which will focus on the care plan and the primary data necessary to ensure the Quality Measures can be inputted, tracked, monitored and extracted for reporting. The second phase will be full implementation, which will include transition to a completely paperless system that can be fully used while in the community.

The overall project will be guided by an Implementation Specialist from Carelogic, who will initially serve as the EHR Implementation Project Developer. With many years of experience doing implementation in like agencies, Qualifacts is uniquely qualified to oversee the development of an implementation plan, and will ensure that all decisions regarding customization will result in the most effective outcomes, such as ease of use, efficient operations, comprehensive reporting and the like. Once a concrete, well-defined implementation plan is established, FSA's Information Technology (IT) Manager will take over primary responsibility for overseeing the implementation. Qualifacts will continue to serve as a consultant and

provide high level oversight throughout implementation. The implementation team will include key employees from CSA and FSA, including the following:

- CSA Director
- Two CSA supervisors
- Director of Client Financial Services
- Director of Continuous Quality Improvement
- IT Manager

It is anticipated that the implementation team will evolve as the project progresses, and participation of some members will be determined based on the current process being implemented. While the EHR will be customized for the CSA, it is essential that components are consistent with those in place for other FSA programs utilizing the EHR. This includes billing functionality and Quality Improvement features for measuring service delivery outcomes. Thus, various staff from FSA support departments will be engaged in the implementation as appropriate to the stage of the project.

EHR Implementation will be moved forward and coordinated through the use of regularly occurring Implementation Team Meetings. The Implementation Team will be comprised of core members, with other FSA staff engaged depending on the stage of implementation. Implementation Team meetings will occur weekly, with the schedule modified based on tasks and the stage of the implementation, but the core Implementation Team will meet no less than bi-weekly. The Risks, Assumptions/Actions, Issues and Decisions (RAID) project management tool will be applied to this project to ensure all members are held accountable for their designated parts of the Implementation Plan. The Chief Administration Officer will provide executive level oversight of the project.

The members of the implementation team from CSA will be particularly valuable in providing important work flow information and feedback. These supervisors will also be highly involved in developing EHR usage training materials, evolving into the system “experts”. They will be involved from the start in creating how the EHR will function for CSA and help to establish the plan for training staff on the day-to-day use of the system. This Train-the-Trainer model is recommended by Qualifacts, and will be used to ensure successful EHR implementation with CSA staff. One CSA Supervisor will be designated the EHR Implementation “champion” and will be charged with ensuring a smooth transition by CSA staff users and promote consistent use of the EHR and digital resources. With the supervisors developed as system experts, they will have the capacity to train and coach existing CSA staff and all newly hired individuals.

Another aspect of the full implementation of the EHR that will support achievement of program goals and the performance expectations of this RFR, is the capacity to build modules within the EHR to ensure compliance with quality measures. The existing paper care plan will be recreated within the EHR, but it will be designed to include required quality measures, such as physical and dental care appointments. Since Carelogic can be mapped to ensure key information is included in service documents, fields for quality measures will mandate data entry, thus ensuring required data is captured. For example, the existing CSA Care Plan has a field for date of last physical. When the Care Plan module is created for the EHR, the field for date of last physical will be programmed so that the Care Plan cannot be completed, signed and saved until that date field is completed. With that date entered onto the Care Plan and into the EHR, reminder

alerts can be programmed so that workers are notified 90 days, 60 days and/or 30 days before the next appointment is due. To further support compliance, alerts can be programmed for supervisors so they are automatically notified through the EHR when physical dates lapse beyond a pre-determined threshold. FSA has complete control over mandated fields, how performance thresholds are set and when reminders and warning alerts are set. This system, of making the required element a default element, will go a long way to support achievement of performance and quality measures. This same system of mandatary fields, warning and alerts has supported successful compliance with Centers for Medicaid and Medicare (CMS) mandatory reporting in other FSA programs. Thus, FSA is confident the system can be mapped to support CSA as well. Mapping and creating customized configured forms and beta testing of reporting will be part of the role of the Qualifacts consultant, the IT Manager and other members of the Implementation Team.

During the EHR implementation process, encrypted e-mail will be integrated into FSA's IT capacity to ensure secure communication with external providers. Following successful implementation, Carelogic's ability to meet meaningful use will be evaluated, and the method of connection to the Mass HIway will be identified and implemented. Part of the Implementation Plan will also include establishing policies and procedures related to EHR use, establishing workflow process for training employees and developing strong audit trails for tracking system access and activity.

The timeframe for the Technology Advancement Project will run throughout the five year budget period, with consultant services, form development, workflow creation and report writing titrating downward as funding decreases and EHR capacity increases. In the preparation budget period, the Carelogic Implementation Project Developer will be required to complete a structured, written Implementation Plan that includes timeframes for achieving various milestones and assigns responsibility for key tasks. The development of the Implementation Plan will begin with a thorough assessment of current capacity, obtained by reviewing existing system set-up and evaluating current manual and electronic workflow processes. Regular meetings of the Implementation Team will ensure Implementation Plan developers have a thorough understanding of program needs. The aim is not to restructure the CSA, but to mold the EHR to support the program. To fully operationalize the EHR, IT consultants will convert multiple paper documents that are currently in use to electronic configurable forms and service documents. These electronic resources will then be mapped to the CSA digital workflow and linked in a way that will support data extraction for reporting. The system must also be configured to accept paper documents (such as physical exams, IEPs etc.) that will be scanned into the EHR. These documents also need to be mapped to the EHR, much the way paper documents are filed in a hard-copy record. Finally, program specific reports need to be created or "written" within the system so that data can be extracted in a user-friendly and meaningful manner. All of these activities will be prioritized for deployment in the Implementation Plan.

Budget period one will be the first phase of actual implementation. FSA anticipates this will be the deployment of the electronic Care Plan. This will be a "soft" implementation, comprised only of entering existing Care Plans into the EHR. This will familiarize staff with the new care plan format and lay the groundwork for gradually transitioning to actually creating electronic care plans and eliminating paper versions in the record. Since the CSA is a large program, clerical support will be provided to assist with data entry. As the program prepares for the digital care plan transition, remote MiFi devices will be deployed to support creation of care plans in the community in the presence of clients. The remainder of

budget period one will be used to continue deployment of the Implementation Plan; including developing and testing other workflows, configurable forms, reports, and training tools in keeping with the written work plan.

It is anticipated that budget period two will be the "go live" phase for full EHR implementation. Ongoing assessment of EHR functionality will be completed, with modifications made as necessary. Upon completion of this phase, all data that is currently maintained in paper records will be transitioned to Carelogic, with full digital recordkeeping for all new clients admitted after the "go live" date. Access to the full EHR from community locations will be available to ensure all staff have access at all times.

Much of the FSA workflow changes and advancement of technology align with innovations currently underway by Qualifacts. By the third budget period, Qualifacts will have deployed a mobile application (App) to support EHR use. Thus, it is in the third budget period that FSA will deploy *Carelogic Mobile,* Qualifacts' App for mobile access to Carelogic. For this initiative to be successful, service documents for mobile platforms will need to be re-installed to align with the system's requirements for *Carelogic Mobile*.

Budget period four will see the development of FSA access to the Mass HIway. We will apply for participant status, evaluate and determine type of access, and develop policies and procedures and monitoring systems for Mass HIway use. Additionally, we will also be enhancing the capacity for communication with providers through the use of other mobile Apps. Finally, in budget period five, FSA will complete a final analysis of the EHR implementation, care coordination and integration and make any needed modifications. We will ensure full functionality with Mass HIway and other communication and platform deployments and operate with a fully functional completely digital EHR for CSA consumers.

The deliverable for this proposed project is a fully functioning, comprehensive electronic health record that will provide consistent and timely reporting and support achievement of quality measures. The EHR will support secure communication with other providers and full functionality with the Mass HIway. Furthermore, the EHR will support integration of care, care planning and care coordination by being fully accessible to all registered users from any community location by putting the electronic health record at the worker's fingertips whenever and wherever it is needed.

The largest percentage of DSRIP funds will be used for consultative services, for both project development and implementation. This includes the Implementation Project Development consultant and additional consultants to support the creation of fully functional EHR modules and configurable forms to replace the entire paper CSA record. This includes, but is not limited to, intake documents, assessment tools, safety plans, care plans, discharge plans and the like. Consultants will also be engaged to support report writing that will be key to measure program performance and to accurately report quality measures. Funds will support temporary IT technicians, if needed, to assist with the development, testing, editing and deployment of configurable forms and reporting features. Funds will also be used to upgrade, configure and deploy laptops used by ICCs for community-based services and to provide internet based access to the EHR from all community locations.

DSRIP funds will also be allocated to the FSA IT Manager for the additional responsibilities of overseeing the development, customization, testing, and implementation of all features of the EHR system; ensuring the sustainability of the EHR investments beyond the funding period. During the preparation budget period only, a small portion of DSRIP funds will be allocated to support other members of the Implementation Team. This will include the Director of Client Financial Services who will be engaged to ensure that the billing interface for CSA is consistent with billing requirements. The Director of Quality will participate on the Implementation Team to ensure that the mapping of quality measures will meet various standards including EEOHS, Medicaid, accreditation and organizational requirements for program monitoring and reporting. This will ensure the Implementation Plan that is developed is comprehensive, considers all operational issues and can be seamlessly integrated into the organization's infrastructure. Additionally, a small portion of funds will be used to provide clerical support to CSA staff during the EHR transition.

Internal support services and departments will provide strong internal resources in support of this project. The Chief Administration Officer will work closely with the IT Manager and oversee the project, and ensure that any barriers to completion are quickly resolved. The Director of Children's Behavioral Health Services, along with designated staff, will serve as members of the Implementation Team to offer insight, aid in decision-making, test EHR modules as they are developed, and assist with training and deployment of the system to the full staff. The Director of Client Financial Services will also participate in planning, decision-making, testing, training, and deployment as appropriate for billing functionalities. The Human Resources Department will provide assistance with screening, recruitment and on-boarding of new employees. The IT Department will provide day-to-day support for all equipment and services. The Department of Continuous Quality Improvement will provide input on data and reporting needs, supporting data collection, aggregation, analysis and reporting decision-making for design, testing and deployment.

FSA has a strong and well-established system for internal evaluation of improvement activities that is an integral part of the organization's Quality Management (QM) Plan. The plan calls for a systemized process to:

- Identify areas for improvement
- Set realistic and measurable goals
- Establish objectives to meet goals, and
- Continually monitor progress

This same system will be applied to the capacity building projects proposed. The existence of an established QM Plan demonstrates FSA's commitment to continuous quality improvement. The QM Plan uses Performance Improvement Targets (specific goals) and Performance Improvement Teams to foster continual change. In some programs and for some goals, specific teams work on the stated objectives; while in other cases, an entire program or department is involved in the improvement activity. Currently, every FSA program and department is required to establish at least one Performance Improvement Target (PIT) each year. The PITs for the CSA will become the capacity funding projects, with these new initiatives flowing seamlessly into the existing QM infrastructure. Once PITs are created and approved by Senior (Executive) Leadership they are monitored by the Department of Continuous Quality Improvement (CQI). PITs must include a stated goal, a rationale for the goal, the measurement activities that will evidence progress toward the goal and quarterly activities that will support goal attainment. Progress toward goals is

monitored through program level staff meetings and QM meetings are required. Minutes of the QM meetings are submitted to CQI along with quarterly PIT progress reports. Quarterly summaries on the progress of the various program's PITs is provided to Senior Leadership. An annual summary of progress toward PITs is provided by CQI to the Chief Executive Officer and the Board of Directors as part of the annual Quality Management and Risk Management report. The application of this system to the capacity funding projects will support continual progress, reporting through the chain of command, and goal achievement in the same way the QM Plan has fostered change for other programs and within the organization.

The project will be evaluated as follows;

1. The Electronic Health Record will be fully implemented by 12/31/2018, with completed evaluation and resulting modifications made by 6/31/2019.
    a. The care plan will developed in the EHR and tested by at least one program staff by 3/31/18.
        i. Evaluation of the care plan will include comprehensive reporting using internal data to test configuration and ensure reporting functionality. This evaluation will be completed by the IT Manager, with assistance from consultants as needed. Evaluation will also include staff feedback regarding the user experience, including reporting. This evaluation will completed no later than 6/30/2018.
    b. The remaining record will be configured by 12/31/2018. This includes evaluation of functionality completed by programs staff, and resulting modifications made by 6/31/2019 by the IT Manager, with assistance from consultants as needed.

Project Two - Workforce Development Plan: The second goal of this project is to strengthen fidelity to Wraparound processes including care planning, care management, and care coordination by cultivating and retaining a highly qualified workforce. This will be achieved through a number of objectives.

The first objective is to sustain the existing workforce by stimulating ongoing skill advancement and nurturing employee talent and expertise. The CSA is fortunate to have a number of workers who have been with the organization since the early days of the program. Our existing philosophy is to value employee expertise and celebrate worker achievements. The Workforce Development Plan builds upon this philosophy demonstrating FSA's profound respect for our greatest resource, our employees. The role of ICC and FP is very specific to CSA. Thus, when staff are hired for the program they may be highly qualified to work with children with Serious Emotional Disturbances and meet the performance expectations for CBHI staffing; but they may not be experienced in Wraparound or the role of ICC. Significant resources are dedicated to cultivating knowledge of Wraparound processes and promoting fidelity to the model. It is essential that FSA has a means to retain qualified individuals and enhance skill development of the two roles. To that end, we propose an initiative to recognize worker expertise, evidenced by advanced training and demonstrated proficiency in established domains, through the Workforce Development Plan. Once designed and deployed, the Workforce Development Plan will serve not only as an employee retention strategy but a strong tool for the recruitment of new employees.

Through an established training plan, staff will be offered opportunities to strengthen their skills, advance

their practice and demonstrate expertise that goes beyond satisfactory job performance. A tiered system will be created that staff can progress through to achieve designation as an advanced practitioner. There is a small number of current CSA staff who, through their own initiative, sought and achieved Wraparound Credentialing in the early years of the program. Building upon what we already have, we will extend this model and make it available to all staff with a goal of eventually having everyone credentialed. The first activity will focus on Tier 1 and Tier 2 Wraparound Credentialing for each of the two CSA roles, ICC and FP. FSA has three individuals who are Certified Wraparound Coaches so much of the work that needs to be done to increase the number of credentialed staff can be made available through these internal resources. Staff seeking to be credentialed will be required to meet set learning and performance thresholds. Each Tier achieved by an employee further advances their practice and expertise while supporting the overarching goal to strengthen fidelity to Wraparound processes.

The Workforce Development Plan will begin in the budget preparation period. The roll-out and achievement of Tier 1 and Tier 2 credentialing for most, if not all, CSA staff will occur in the first two years of funding. In the third year, the CSA will introduce additional ways to advance Wraparound practice. The additional steps will relate to further education and proficiency thresholds built from other evidence-based models such as Models for Collaborative Problem Solving, Trauma Focused Cognitive Behavioral Therapy

and Motivational Interviewing. FSA believes that this structured plan with tiers of achievement and standardized credentialing for reaching education and proficiency thresholds, will serve as a strong retention strategy and support fidelity to Wraparound as well as advance worker's skills in care planning, care management, care coordination and team building. Ultimately, access to services is predicated upon having sufficient well-qualified staff to meet the needs of the program. FSA is fortunate to have a strong core of well-qualified and experienced staff. It is essential that we strive to retain these individuals in a meaningful way that promotes professional growth. It is also critical that we develop a means to offer this same learning trajectory to employees who joined the CSA after the initial ramp-up and those who will join the program in future years.

Another strategy for recruiting and retaining highly qualified staff aligns with the organization's existing philosophies for Human Resource management. Overall, FSA has an extremely good rate of retention. We believe that as an organization, if we treat people well, provide ample opportunities for growth and ensure workers have the tools they need to get the job done, they will remain engaged, productive and enjoy a meaningful employment experience. This formula for retaining staff has also made FSA a desirable employer for many of the fields for which we recruit. Employees are valued and this sentiment is communicated regularly and echoed by the Executive Leadership team. The development and deployed of the Workforce Development Plan further supports this philosophy.

It is anticipated that the Workforce Development Plan will extend throughout the DSRIP funding period and will be fully sustainable by the end of the funding period as detailed in the sustainability response (See 6.5 Sustainability). It is recognized that individuals will be at different levels on the Plan at any given time. Certified Wraparound Coaches are prepared to start immediately to foster credentialing for additional staff. As new initiatives are built, we will expand the training capacity within the CSA, using a train-the-trainer model whenever possible. We will continually seek to strengthen the leadership team to serve as educators and coaches for newly hired staff, making the Workforce Development Plan cost-effective and sustainable. The resources for training will continue to be evaluated for inclusion in the budgetary process.

DSRIP funding will be used by FSA to pay for external educators to provide specific trainings and workshops that will promote fidelity to Wraparound processes. Funds will also be provided to recognize internal staff who will serve as coaches for Wraparound credentialing in addition to their primary role. The additional work required of the staff to become Tier 1 and Tier 2 credentialed will also be recognized using DSRIP funds. FSA has existing staff qualified to provide Wraparound credentialing. We also have sufficient space to offering group and individual education sessions. Equipment to support educational initiatives is available in the form of laptops, projectors, wall mounted flat screen monitors, etc. The supervision and coaching structure already exists within the CSA creating fertile ground to support these efforts. Access to contemporary technology that will be available through the Technology Advancement project will further support these goals.

By the end of the funding period, it is anticipated that all staff employed longer than six months will be credentialed for both Tier 1 and all staff employed longer that one year will achieve Tier 2 credentialing aligned with the National Wraparound Implementation Academy model. In addition, a minimum of two supervisors will be certified for Tier 2 and will prepared to train and coach staff on an ongoing basis. Additionally, all staff will have completed training for Motivational Interviewing and demonstrate proficiency and fidelity to the model. All staff will have completed Collaborative Problem Solving and will have attended one workshops/trainings on the delivery of trauma-informed care. Finally, by the end of the

funding period, at least five staff will have completed certification for the advanced level of Collaborative Problem Solving. This comprehensive train-the-trainer model further strengthens our ability to sustain a higher level of expertise in the fidelity of the Wraparound model in the future.

As explained earlier, the CSA already has staff that can serve as Wraparound coaches. The CSA also has Tier 1 and Tier 2 credentialed staff who can serve as mentors and role models for those staff seeking to achieve credentialing. The use of these current internal resources along with the program's supervisory team makes this initiative cost-effective and sustainable.

The second goal of the Workforce Development Plan involves collaboration with the other CSAs in the Southeast region. Together, the CSAs will create a shared learning library. All of the CSAs in the region will supply content for the library. The content will be intended to support education in Wraparound processes, fidelity to the ten principles of Wraparound, Care Planning, Care Coordination and Integration of Care.

Together, the Directors from the CSAs in the Southeast region have identified focal areas that address key skills for successful delivery of Wraparound services. These areas include:

- Motivational Interviewing
- Diagnostic Formulation and Treatment Planning
- Collaborative Problem Solving
- Attachment, Regulation and Competency Framework
- Coordination of Care for Medically Complex Youth, and
- Wraparound Certification

Collectively, every CSA in the Southeast region will benefit from the efforts and families served will benefit from a more informed team delivering CSA services. The specifics of the content, the format for storing the content and the protocol for access will be decided by representative from the CSAs who will collaborate on the project. This shared resource will strengthen collaboration between CSAs. It makes training more cost-effective by pooling resources instead of replicating training efforts in each individual CSA. It also helps to make CSA services consistent in the region since most, if not all CSA staff, will be educated from the same uniform content. A small percentage of DSRIP funds will be reserved for the development of the training resource library.

The final goal of the Workforce Development Plan involves strengthening the Human Resources (HR) Department's recruitment, screening and hiring practices to ensure vacant positions are filled in a timely manner and with qualified individuals. FSA already has a fully functional HR Department that provides recruitment, screening and hiring. This objective will support the need to fill CSA positions more quickly to maintain our capacity to offer timely access to services. A small amount of capacity funding will be applied to enhance recruitment.

FSA follows a comprehensive recruitment plan to ensure that employees for CSA adequately represent the communities served. Through this funding, we will look to further advance the language capacity of the program in response to referral trends. A multifaceted approach will include on-line targeted advertising, college networking, sustaining relationships with local career centers, and word-of mouth referrals. FSA routinely uses an Applicant Tracking System, which provides an efficient and cost effective way to increase our on-line presence. The applicant tracking system connects FSA to Indeed, a world-wide employment-related search engine for job listings. Indeed reaches a large and diverse population and has historically

provided a good pool of candidates. Indeed will be the primary on-line resource and will be enhanced through focused advertising to reach diverse populations. We will also use O Jornal, which is the ethnic division of The Herald News, the newspaper distributed in the CSA catchment area. In the past, FSA has had success with posting on other boards, such as Craig's List and Linked In, and will include that in our on-line resources to advertise and network. Additionally, FSA's Facebook presence and corporate website will highlight new opportunities.

FSA already works with several area colleges and universities to recruit culturally and linguistically diverse candidates with Associates, Bachelors and Masters level degrees. We work with Bristol Community College in Fall River, UMASS Dartmouth, Bridgewater State University, Rhode Island College, University of Rhode Island, and Community College of RI. FSA fosters close relationships with the local colleges, in an effort to increase internship placements, thereby increasing referrals and potential hires. In many cases we can connect to a target population (e.g. Spanish or Portuguese speaking) through affiliations with campus groups. Networking with Department Deans, posting on job boards, and attending Job Fairs have all been productive components of the college recruitment plans. Specialized training in CBHI services is beginning to evolve in Massachusetts' colleges and universities and FSA will apply capacity funding to support the development of strong affiliations with these institutes of higher learning to recruit qualified candidates.

We also utilize the Career Center in Fall River that networks to the surrounding areas by posting FSA positions on their state website Job Quest. This too reaches a broad and diverse population. On-going relationships with career counselors are helpful in identifying possible candidates. The applicants from these locations are an excellent representation of the local community. Additionally, we are well connected to many different community organizations and have found success with word-of-mouth referrals. Through this funding, current employees will be incentivized to spread the word about job openings through an Employee Referral Incentive Program.

The evaluation and measurement strategy tor the Workforce Development Plan will include the following:

Employee readiness to perform and meet job expectations will be measured by a pre-training employee survey, focused on staff training opportunities, skill development and job satisfaction. The Continuous Quality Improvement department will distribute survey via survey monkey to 15 CSA staff prior to the tier 1 wraparound credentialing training. 10 CSA employees will complete tier one training by 12/31/2018. Surveys will be re-distributed no later than 3 months following the completion of each tier.

Member satisfaction surveys will be distributed by the Continuous Quality Improvement department to all enrolled caretakers annually, the first of which will be completed by June 1, 2019. Specific questions will be added to the surveys each year to glean information regarding the impact of the enhanced training on the member's experience in wraparound.
Survey results will be shared with program leadership by 9/1/2019. Goals for development plan will be added if evidenced in data.

The Human Resource Department will monitor CSA staff retention annually and share the results with program leadership by January of 2019. The goal for CSA staff retention is 85 %.

FSA is confident that the strong governance structure of our organization, our solid fiscal status and our demonstrated ability to offer high quality human services favorably positions us to succeed in the proposed

projects. We have a solid understanding of the State's DSRIP program and goals. We have made significant progress in fostering a meaningful relationship with one of the state's 18 designated ACOs, the Steward Health Care Network. We believe the proposed projects are realistic will support achievement of the goals described in the RFR. The FSA CSA is one of the largest programs in the State, with families from neighboring communities requesting to be serviced through our program The FSA CSA is a strong program with proven effectiveness and demonstrated fidelity to Wraparound processes. The Implementation Plan and Timeline, Budget Report and Narrative and Sustainability modules that follow provides further evidence of our understanding and capacity to meet the stated objectives.

Family Service Association
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SECTION 6.4 PROPOSED PROJECT AND INVESTMENT PLAN
B. PROJECT TEAMS

WORKFORCE DEVELOPMENT PLAN

The following individuals will provide primary support to the proposed Workforce Development Plan:

- Chief Program Officer – Sharon E. Ford
- Director of Children's Behavioral Health Services – Sharon LaFleur
- Senior Care Coordinator – Katherine Kasheeta
- Senior Care Coordinator – Emily Kelleher

Job descriptions and resumes for each of these primary project team members are provided. In additional, internal FSA resources will be applied to this project through the following positions:

- Director of Human Resources – Sheila Muise
- Human Resources Coordinator – Susan Hancock

Job descriptions are provided for these internal supports.

TECHNOLOGY ADVANCEMENT

The following individuals will provide primary support to the proposed Workforce Development Plan:

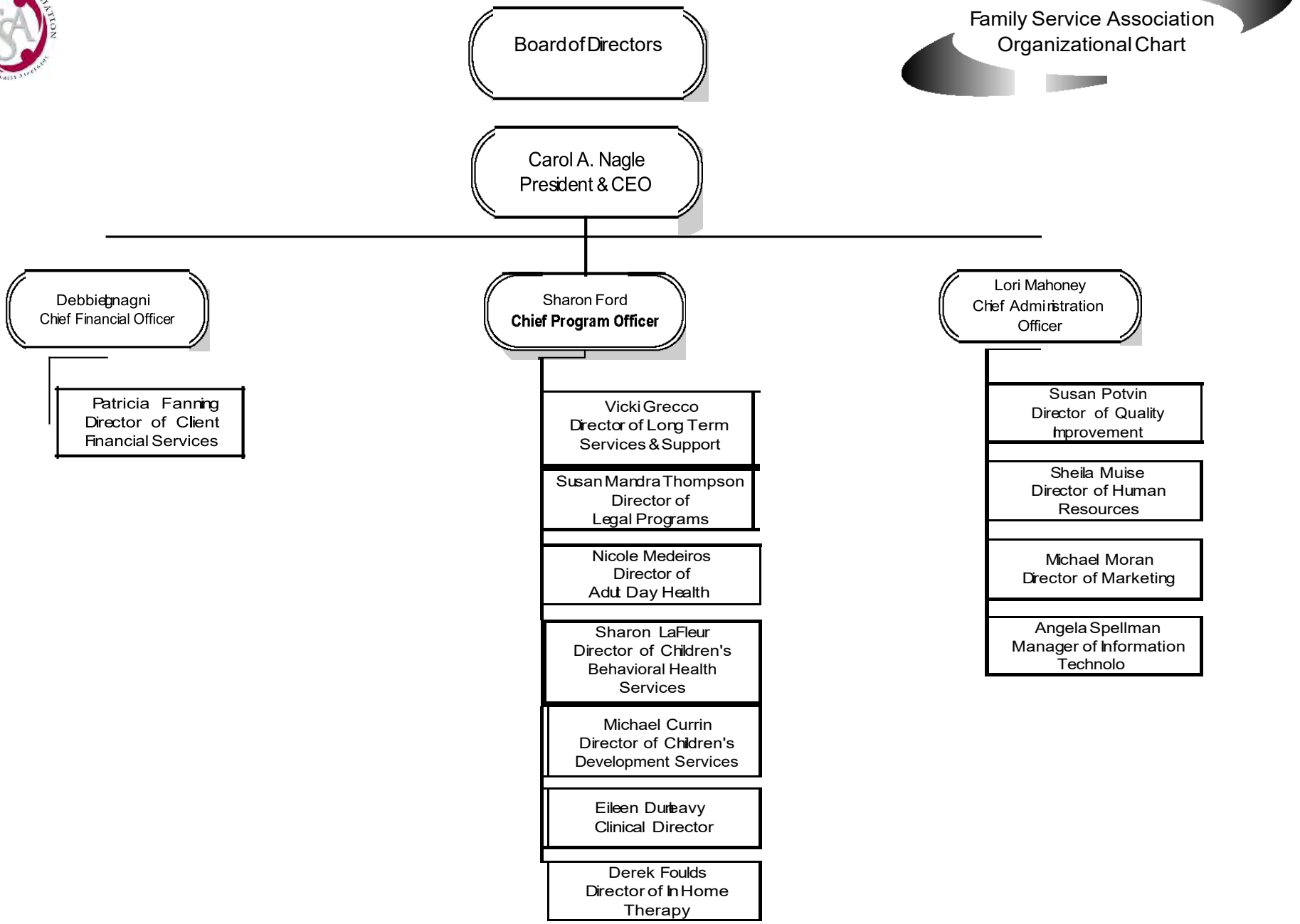
- Chief Administration Officer – Lori JB Mahoney
- Information Technology Manager – Angela J. Spellman
- Carelogic Implementation Specialist – Tina Kirkpatrick
- Other IT Consultants – To Be Determined
- Director of Children's Behavioral Health Services – Sharon LaFleur
- Senior Care Coordinator – Katherine Kasheeta
- Senior Care Coordinator – Emily Kelleher

Job descriptions and resumes for each of these primary project team members are provided. In additional, internal FSA resources will be applied to this project through the following positions:

- Senior Information Technology Technician – Charles Mickle
- Help Desk Technician – Joseph Vickery
- Director of Quality Improvement – Susan K. Potvin
- Director of Client Financial Services – Patricia Fanning

Job descriptions are provided for these internal supports.

Family Service Association Organizational Chart



Family Service Association

101 Rock Street ❖ Fall River, MA 02720

508-678-7542 ❖ www.frfsa.org

Job Description

Position: Chief Program Officer

Program: Administration

FLSA Status: Exempt

WCC Code: (8810)

Accountability: Chief Executive Officer

Job Summary:

The Chief Program Officer plans, organizes, and oversees all activities of the organization's programs and collaborates with the President/Chief Executive Officer for the overall administration of the agency. The Chief Program Officer is directly responsible for the development, management, and quality improvement activities of all programs: Specialized Adult, Youth, and Clinical. Functions as an integral member of the Senior Leadership team, and is responsible for all agency activity in the President's absence. S/he is responsible for the management of organizational activities that ensure a high level of quality commensurate with the mission of the organization and interests of the Board of Directors, clients, employees, and other stakeholders. S/he is required to clearly communicate current information regarding community needs, industry trends, and changes in the regulatory environment to the Chief Executive Officer.

Duties and Responsibilities:

1. Direct and participate in the planning process for future development and growth of the agency. Market and expand existing programs while developing new initiatives in order to strengthen the Agency's funding base.
2. Develop programs and services consistent with agency purpose and the needs of the community, and ensure programs are responsive to the needs of the community, client, referral and funding sources.
3. Keep informed of national, regional and local developments and trends the impact operations and facilitate organizational adaptive changed as needed.
4. Delegate authority to provide program direction to subordinate personnel and hold them accountable for the performance of their programs and/or departments, ensuring full organizational alignment with its mission, vision and values. Participate in the development and monitoring of service and financial targets, ensuring targets are met.
5. Provide individual and team supervision to Program Leaders as warranted and appropriate according to the Agency supervisory structure. Participate in the hiring, training, and timely performance evaluation of all staff.
6. Ensure coordination and integration of programs so that services are as seamless as possible in order to flexibly respond to the changing needs of clients.
7. Utilize program evaluation methodology, MIS, and financial data to monitor service and financial goals, and adjust service delivery as indicated.
8. Oversee program compliance with agency, licensure, funding source and accreditation regulations, standards, policy and procedures.
9. Participate in committees and assigned Quality Improvement activities.
10. Perform additional duties and responsibilities as directed by the CEO, up to and including the oversight and leadership of additional departments.

Revised 3/2012, 3/2013, 06/2017
Reviewed 3/2014, 4/2106

Education and Experience:
Master's Degree in human services and a minimum of ten years' experience in program administration. Demonstrated competence in planning, designing, and implementing programs, leadership, and team building.

I have read, understand and accept the responsibilities outlined in this job description.

Signature:_____ **Date:** _____

Supervisor:_____ **Date:** _____

Family Service Association

101 Rock Street ❖ Fall River, MA 02720

508-678-7542 ❖ www.frfsa.org

Job Description

Position: Director of Children's Behavioral Health Services

Program: Community Service Agency / Therapeutic Mentoring/ Family Resource Center

FLSA Status: Exempt

WCC Code: (8810)

Accountability: Chief Program Officer

Job Summary:

To provide administrative support and clinical supervision for the personnel involved at the Community Service Agency(CSA), consisting of two main components: Intensive Care Coordination (ICC) and Caregiver Peer to Peer Support (Family Partner). To provide for needed care coordination for each child and family admitted to the program and to assure that such service is delivered in a timely and regular fashion. To coordinate all reporting functions between the agency's CSA team and the referring Managed Care Entity. The Program Director will supervise the Senior Care Coordinators and Senior Family Partners. The Director must also lead a local systems of care committee consisting of local providers and state agencies.

Duties and Responsibilities:

1. The Program Director develops and manages the intensive care coordination services in a manner that is consistent with *Systems of Care* philosophy and *Wraparound* planning principles and adheres to the four phases of *Wraparound* for the consumers of the Community Service Agency .
2. The Program Director addresses a variety of complex treatment and system issues. S/he ensures that staff are skilled in providing education and planning regarding treatment access and service needs, parenting skills, conflict resolution, mediation, risk management/safety planning and intervention, and family advocacy and support.
3. The Program Director ensures that the CSA assists the youth to access medical, educational, social, therapeutic, and other services identified in his/her ICP, and is responsible for developing a plan to initiate and guide those service interventions.
4. Assure the UR and UM activity is carried out in a timely fashion.
5. Prepare productivity reports and liaison with the agency's billing department.
6. Perform any duties needed for the efficient running of the program.
7. Respond to reasonable expectations of the Agency and/or supervisor.
8. The Director ensures that a licensed, master's level senior care coordinator provides adequate supervision to each Intensive Care Coordinator and family partner on a weekly basis. The Director ensures that each family partner is also supervised weekly by a Senior Family Partner.
9. The Program Director participates in all network management, utilization management, and quality management initiatives and meetings.
10. Program Director participates in all fidelity-monitoring activities required by MHBP and the five MCE payers'. Program Director will adhere to a standard Operations Manual (and all subsequent revisions), that includes requirements related to successful completion of skill- and competency-based training, care management provision and supervision requirements, care planning requirements, including a process for resolving disputes between team members, reporting of adverse incidents, and consent requirements. The Operations Manual will incorporate statewide interagency agreements concerning the role and responsibilities of representatives of each child-serving agency.
11. The Program Director must comply with all requirements and standards in the ICC Operations Manual
12. The Program Director develops and maintains policies and procedures relating to all components of the ICC service that are consistent with the guidelines and standards in the ICC Operations Manual.
13. The Program Director ensures all new and existing staff will be trained according to the guidelines and standards identified in the ICC Operations Manual.
14. The Program Director ensures that all services are provided in a professional manner, ensuring privacy, safety and respecting the youth and family's dignity and right to choose.

Education and Experience:
A Masters Degree with a license from an accredited School of Social Work or Counseling; LICSW or LMHC with a minimum of five (5) years of experience working with the target population; experience in navigating any of the child/family-serving systems; and experience advocating for family members who are involved with behavioral health systems.

I have read, understand and accept the responsibilities outlined in this job description.

Signature: _____Date:_____

Supervisor: _____Date: _____

Family Service Association

101 Rock Street ❖ Fall River, MA 02720

508-678-7542 ❖ www.frfsa.org

Job Description

Position: Senior Care Coordinator

Program: Community Service Agency

FLSA Status: Exempt

WCC Code: (8742)

Accountability: CSA Program Director

Job Summary:

The Senior Care Coordinator (SCC) provides intensive care coordination services to children referred by the five MassHealth Managed Care Entities (MCE's) – Boston Medical Center, HealthNet Plan, Fallon Community Health Plan, the Massachusetts Behavioral Health Partnership, Neighborhood Health Plan, and Network Health. Under the supervision of the CSA Program Director, the Senior Care Coordinator (SCC) serves as a supervisor on the Community Service Agency team. The Senior Care Coordinator (SCC) co-supervises Family Partners on a weekly basis along with a Senior Family Partner. The SCC also supervises the ICC's on a weekly basis. The SCC, while implementing the wraparound process facilitates the development of the Care Planning Team, who utilizes multiple tools, including strength-based assessments, inclusive of CANS in conjunction with a comprehensive assessment and other clinical information to organize and guide the development of an Individual Care Plan and a risk management/safety plan to improve the lives of families who have children with mental health needs

Duties and Responsibilities:

1. Supervise care coordinators and family partners on a weekly basis in group and individual settings.
2. See children and families as assigned for ICC intake and/or care coordination while adhering to the principles of wraparound.
3. Should be knowledgeable and experienced in the use of several of the following treatment modalities: individuals, family, child, and group. Should understand the concepts of wraparound services and strength-based approached to providing supports.
4. Have a willingness and ability to work with SED, DMH and DCF populations.
5. Willingness and ability to work flexible hours, including evenings to meet the clinical needs of the child and family.
6. Provide consultation and education to families.
7. Participate in 24 hour on call emergency pager coverage on rotating basis to address urgent child or family crises.
8. Triage referrals and provide referral resource with accurate and timely availability of needed resources.
9. Maintain paperwork requirements and timeframes of MBHP, the five MassHealth Managed Care Entities (MCE's) – Boston Medical Center, HealthNet Plan, Fallon Community Health Plan and the agency.
10. Respond to reasonable expectations of the Agency and/or supervisor.
11. . Assist in maintaining all policies and procedures related to all components of the community service agency. Senior care coordinators assist in ensuring all new and existing staff will be trained on these policies and procedures.
12. Provide orientation, coaching and training to newly hired staff.
13. Learn billing and insurance systems that interface with ICC. Complete authorizations when needed. Assist staff with insurance authorization problems and contact MCE's as needed.
14. Understand and demonstrate commitment to agency mission, values and philosophy in performing skill specific to role.
15. Maintain all ethical and legal requirements of the Agency.
16. Assume responsibility for meeting and maintaining all licensing, COA or agency requirements for personal health, training or other certifications.

Revised 4/2011, 3/2012,3/2013
Reviewed 3/2014, 04/2016

Education and Experience:
Must be a MA LICSW with a Master Degree in Social Work or Masters in Counseling/Psychology or a related field with an LMHC from an accredited school. Must have skills necessary to engage and work with others from diverse backgrounds. Maintain a nonjudgmental attitude toward families. Maintain required licenses and certifications to perform role. Must have experience working with children and families. Must be willing to work with SED population and be able to work flexible hours in order to meet the clinical needs of the child and family.

I have read, understand and accept the responsibilities outlined in this job description.

Signature: _____ **Date:** _____

Supervisor: _____ **Date:** _____

Revised 4/2011, 3/2012,3/2013
Reviewed 3/2014, 04/2016

Family Service Association

101 Rock Street ❖ Fall River, MA 02720

508-678-7542 ❖ www.frfsa.org

Job Description

Position: Director of Human Resources

Program: Administration

FLSA Status: Exempt

WCC Code: (8810)

Accountability: **The Human Resources Manager is directly accountable to the Chief Administration Officer.**

Job Summary:

The Director of Human Resources s is responsible for all aspects of the Human Resource function.

Duties and Responsibilities:

1. Administer Human Resource policies and procedures in compliance with governing laws and regulations. Conduct routine review and recommend revision of Human Resource policy and procedures when appropriate. Advised/assist employees and leadership regarding policy and procedures.
2. Advise leadership regarding Human Resource issues such as employee development, performance management, and disciplinary actions. Administer and manage all employee termination procedures.
3. Assess leadership training needs to provide/coordinate regular HR training as required. Work with leadership to reduce turnover and to improve retention.
4. Develop, initiate and coordinate employment programs, including sourcing, recruiting, screening and (for some positions) interviewing for leaders, employees and interns. Manage all new employee processing and orientation.
5. Accurately maintain Human Resource files to ensure compliance with State and Federal regulations.
6. Coordinate and initiate mandated employee training when appropriate, including but not limited to sexual harassment preventions, environmental safety, etc.
7. Maintain and prepare all required reports, including EEO, and salary survey reports as required.
8. Monitor timely completion of introductory and annual performance evaluations.
9. Participate in monthly leadership meetings and attend other seminars as needed.
10. Responsible for administration of the Agency's Workers' Compensation program, including claims management, prevention and litigation.
11. Responsible for administration of FMLA, ADA, COBRA, etc.
12. Oversee all employee benefit programs, including medical, dental, life, disability, pension, etc. Maintain records and overall compliance for all benefits, eligibility and employee notifications for pension.
13. Monitor and manage unemployment claims in conjunction with DUA Dollar for Dollar reimbursement protocols.
14. Respond to reasonable expectations of the agency and/or supervisor.

Education and Experience:

Bachelor's Degree required, Master's preferred, and at least 5 years' experience in a human resource leadership position.

I have read, understand and accept the responsibilities outlined in this job description.

Signature:_____ **Date:**_____

Supervisor:_____ **Date:** _____

Developed 8/2016
Revised 03/2017

Family Service Association
101 Rock Street ❖ Fall River, MA 02720
508-678-7542 ❖ www.frfsa.org

Job Description

Position: Human Resources Coordinator

Program: Administration

FLSA Status: Non-Exempt

WCC Code: (8810)

Accountability: The Human Resources Coordinator is directly accountable to the Director of Human Resources.

Job Summary:
Provides support in functional areas of the HR Department, which includes recruitment and employment, Human Resource records, clerical, and other support as needed.

Duties and Responsibilities:

1. Coordinate the recruitment process, including job postings, candidate screening, applicant tracking, reference checking and hiring. Coordinate pre-employment physicals/drug screens and ensure all pre-employment requirements are met.
2. Work directly with Applicant Tracking vendor to resolve issues. Coordinate hire process, including new employee orientation, and entering data for new hires into Paylocity, Red Cloud, Carelogic and e-Verify. Ensure license, certification, TB, CPR, First Aide, drivers' license, and other data needed for regulatory compliance is entered. Communicate new hire information to other departments. Enter Introductory Evaluations and Individualized Orientation Paperwork.
3. Ensure all files are in compliance with government laws as advised by the Director of Human Resources. Assist in maintaining all HR files including restricted and confidential material.
4. Coordinate random drug screening process and document consistently, including scheduling random testing.
5. Assist in maintaining and updating staff licensure and credentials, TB, CPR, First Aide, and other data related to regulatory requirements.
6. Provide prompt response to employees and leadership regarding HR questions and information.
7. Provide clerical support, including ordering supplies, completing employment verifications, and ensuring that employee documentation is filed appropriately.
8. Responsible for incoming and outgoing mail such as sorting, posting etc.
9. Perform clerical tasks as assigned, including maintaining the employee Sunshine fund.
10. Maintain open communication with Director of Human Resources and H.R. Generalist and apprise same of any potential problems.
11. Provide support to other HR functions as needed, including benefit administration, CORI processing, LOA, etc..
12. Respond to reasonable expectations of the Agency and/or supervisor.

Education and Experience:
High School diploma, Associates Degree preferred, or 1-3 years of H.R. experience. Office experience required with some basic HR knowledge. Experience working with HR database required. Effective oral and written communication skills as well as excellent interpersonal skills required.

I have read, understand and accept the responsibilities outlined in this job description.

Signature: _____ **Date:** _____

Supervisor: _____ **Date:** _____

Revised 4/2011, 3/2012, 1/2013, 6/2014, 4/2016

Family Service Association

101 Rock Street ❖ Fall River, MA 02720

508-678-7542 ❖ www.frfsa.org

Job Description

Position: Chief Administration Officer

Program: Administration

FLSA Status: Exempt

WCC Code: (8810)

Accountability: The Chief Administration Officer is directly accountable to the President/Chief Executive Officer

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Job Summary:

The position of Chief Administration Officer (CAO) plans, organizes, and oversees all activities of agency support services and collaborates with the President/Chief Executive Officer for the overall administration of these departments. The Chief Administration Officer is directly responsible for the development, management, and quality improvement activities of Human Resources, Information Technology, Quality Improvement, Development, and Buildings and Grounds. S/he is responsible for the management of organizational activities that ensure a high level of service quality commensurate with the mission of the organization and interests of the Board of Directors, clients, employees, and other stakeholders. S/he is required to clearly communicate current information regarding industry trends and changes in the regulatory environment to the Chief Executive Officer.

Duties and Responsibilities:

1. Participate in the planning process for future development and growth of the agency, and ensure appropriate service support of those plans. Develop support services consistent with agency purpose and the needs of the community.
2. Oversee the development, maintenance, and implementation of excellent standards of service within the organization, following appropriate code of ethics.
3. Keep informed of national, regional and local developments and legal issues that impact service operations and facilitate organizational adaptive changed as needed.
4. Ensures organization compliance with all laws and regulations related to IT, HR, Safety, and COA accreditations. Provide support to program compliance activity as appropriate.
5. Delegate authority to provide department direction to subordinate employees and hold them accountable for the performance of their departments.
6. Facilitate and ensure systems alignment within all support departments and between support departments and programs.
7. Actively participate in committees and assigned Quality Improvement activities.
8. Monitor overall risk management functions.
9. Perform additional duties and responsibilities as directed by the CEO.

Education and Experience:

Minimum of Master's degree in the field of business, or related field. Minimum of ten years of related experience with accountability for a large number of employees.

I have read, understand and accept the responsibilities outlined in this job description.

Signature:_____ **Date** _____

Supervisor: _____ **Date:** _____

Revised 3/2012, 4/2016
Reviewed 5/2017

Family Service Association

101 Rock Street❖Fall River, MA 02720
508-678-7542 ❖ www.frfsa.org

Job Description

Position: Manager of Information Technology

Program: IT

FLSA Status: Exempt

Accountability: Directly accountable to the Chief Administration Officer

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Job Summary: This position provides leadership and is responsible for designing, organizing, modifying, and supporting all matters of information management, application of technology, and connectivity for all FSA locations. It is also responsible for the oversight of the EMR, including full implementation, planning, design, training, support and maintenance. Manages the staff, equipment and expense associated with FSA's IT functions.

Duties and Responsibilities:

1. Collaborate with consultants to identify areas where change, use or increased use of automated systems would provide increase speed, accuracy or efficiency in agency operations. Research and recommend innovative, and where possible automated approaches for system administration tasks. Identify approaches that leverage our resources and provide economies of scale.
2. Provide technical expertise to Senior and Program Leadership.
3. Develop business case justifications and cost/benefit analyses for Information Technology spending and initiatives. Lead acquisition of technology inclusive of computers, phones, copiers and other technological systems.
4. Manage technology inventory (hardware and software) to include procurement, installation, configuration, recordkeeping and disposal.
5. Establish service level agreements with internal and external customers and service providers and monitor service delivery to ensure the agreed targets and standards are met.
6. Assist with all aspects of the implementation of new applications and modules as it relates to Electronic Medical Records. Lead all aspects of new program implementation. Development, implementation and maintenance of new forms by program into the system.
7. Assist with EMR training and education of software upgrades, new features and new functionality. Responsible for troubleshooting and completing application issues and trouble tickets (Soffront and CLHelp), and reporting to the software vendor.
8. Act as Chairperson of the Carelogic Improvement Team, as well as a liaison to the all users and leadership in order to ensure that all issues are resolved in a timely manner. Provide consultant level support and on the job coaching and mentoring for all users as needed
9. Assist with the advancement of clinical applications, interfaces, data migration and reporting of the EMR software. Provide administrative reports as requested by Leadership.
10. Assist with the creation of policies and procedures for all IT areas, including EMR processes and workflows.
11. Other reasonable duties as assigned by the organization and your supervisor.

Education and Experience:

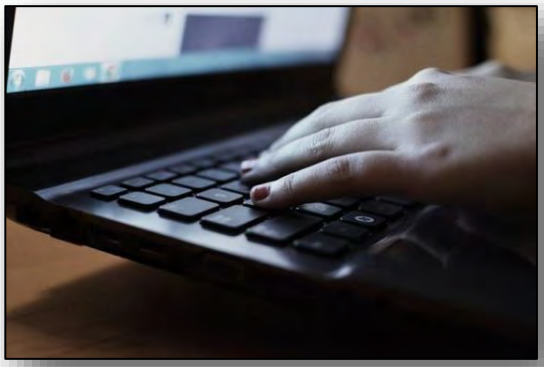
Bachelor's degree in computer sciences, or graduate of accredited technical school preferred. Associates degree or equivalent experience required. A minimum of five years' experience in the IT field, including 2 years EMR implementation, network design, and project management and at least 2 years of supervisory experience is required. Knowledge of SQL programming and Crystal reports is highly desirable.

Signature:_____ **Date:**_____

Revised 8/2015, 6/2016, 4/2017,05/2017

Thank you for choosing Qualifacts (QSI) as your new electronic health records partner. The Qualifacts Implementation Team would like to welcome you to the CareLogic community.

Over the course of the next few months, your Qualifacts project manager (PM) and implementation specialist (IS) will guide you through the configuration, testing, and deployment of CareLogic to best meet the needs of your agency. This process will consist of understanding your current business processes (workflows) and assisting you in the translation of these into a best practice future business processes (workflows) setup within CareLogic in order to maximize efficiencies in both consumer care and revenue lifecycles.



Your dedicated Implementation Specialist is the CareLogic software subject matter expert assigned to the project. The IS will be responsible for system training and configuration guidance on how to setup CareLogic to best meet the agency's business needs.

The Implementation Specialist has an in-depth knowledge of the product and industry standards. The primary goal is to establish successful relationships with the customer and their use of the product presents opportunities beyond standard customer support. Some of these areas include assessments, recommendations on best-use cases, and more complex needs of the product. Responsibilities of the IS include:

- Establishing stronger relationships with Executive CareLogic sponsors at the agency
- Measuring customer satisfaction, reference ability, and effective use of the system
- Project meeting facilitation
- Project plan maintenance
- Manage staff to task completion per timeliness in customer project plan
- Status meeting agendas/minutes and other project controls
- Liaison between customer project team and QSI project team – handling logistics and communication
- Issues resolution
- Identifies and manages trainers for the project
- Oversees issue management for the project

TINA KIRKPATRICK – Information Specialist

PROFESSIONAL EXPERIENCE:

Customer Success Manager/Implementation Specialist
Qualifacts Systems Inc - Jan 2015 to Present

Manager of Implementation
Qualifacts Systems Inc - Aug 2013 to Dec 2014

Project Manager
Qualifacts Systems Inc - June 2009 to Aug 2013

Director of Implementation and Training
CRC Health Group - Sep 2004 to June 2009

Billing Manager
Genesis HealthCare - November 1996 to September 2004

EDUCATION:

AIU (American InterContinental University)
BA, Business Management, Healthcare Administration

Family Service Association
101 Rock Street ❖ Fall River, MA 02720
508-678-7542 ❖ www.frfsa.org

Job Description

Position: Senior IT Technician
Program: M.I.S.
FLSA Status: Non-Exempt
WCC Code: (8810)

Accountability: The Senior IT Technician is directly responsible to the IT Manager

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Job Summary:
Maintains inventory of all computer equipment and software. Ensures that all computer hardware and software meet minimum standards. Maintains computers, checks for viruses, completes back-ups, loads new software, replaces failed cards, and is responsible for daily monitoring of the network. Performs data input into word processing, database, and reporting software.

Duties and Responsibilities:

1. Maintains an inventory of all computer hardware and software including serial numbers, location, and users associated with said hardware. Completes physical inventory checks and inspects computers for non-standard software as requested.
2. Remains current on the procedures for installing and running various programs on user machines. These programs include virus detection, compression, decompression, back-up/restore and other programs used for computer maintenance and upkeep.
3. Responsible for ensuring that periodic backup of critical data is accomplished according to procedure and that the tapes or disks are stored in a secure location. The Senior IT technician is also responsible for accomplishing the restoration of some or all of this data if needed.
4. Maintains sufficient knowledge of computer operation, components, and software to identify when repair or replacement is required. Reports detailed information on current or potential problems to the M.I.S. Supervisor for further instructions.
5. When a local area network (LAN) exists, follows written procedures to keep the LAN running efficiently. This includes, but is not limited to: monitoring workstations on the LAN, resetting LAN components (hubs, workstations, servers, etc) configuring the file server shared drives, maintaining user account information, and providing support to users on the use of LAN resources.
6. Trains users to use programs including word processing, spreadsheet tools, e-mail software and other applicable software programs.
7. Creates statistical reports and special projects as required.
8. Problems the Senior IT Technician is unable to resolve are elevated to the IT manager or other designated support person.
9. Performs data entry as required.
10. Performs other job duties as assigned.

Education and Experience:
High School Diploma or equivalent. Advanced knowledge of Microsoft products is required including use of keyboard, mouse and standard Microsoft menu systems. Must have advanced knowledge of computer installing and maintaining computer hardware. Ability to operate a variety of word-processing, database managers and report writer programs. Ability to travel within the agency's service area or to other locations as needed.

I have read, understand and accept the responsibilities outlined in this job description.

Signature:_____ **Date:**_____

Reviewed 4/2011, Reviewed 3/2012, 4/2014, 05/2016

Supervisor:_____Date: _____

Family Service Association

101 Rock Street ❖ Fall River, MA 02720
508-678-7542 ❖ www.frfsa.org

Job Description

Position: Help Desk Technician

Program: M.I.S.

FLSA Status: Non-exempt

WCC Code: (8810)

Accountability: The Help Desk Technician is directly responsible to the IT Manager

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Job Summary:
Provide computer users with first-level support covering a variety of questions on systems, software, hardware, peripherals, etc.

Duties and Responsibilities:

1. Serve as primary contact for computer user's questions/problems.
2. Provide general maintenance and maintain inventory of workstations, software and peripherals.
3. Provide technical support to all levels of PC users both on the telephone and in person.
4. Analyze and understand staff needs and objectives while maintaining a prioritized list of projects based on those needs and the organizations strategic plan.
5. Prioritize and complete setup and installation of new equipment.
6. Assist users in understanding available help desk services.
7. Analyze, document and evaluate alternative solutions from within a team environment.
8. Assist other MIS team members with issues relating to the use and management of technology provided by FSA.
9. Perform associated administrative/documentation tasks as assigned; refer more complex problems to Senior IT Technician according to procedures.
10. Assist in end user training in areas of PC, network, internet and email usage.
11. Perform, as requested, duties relating to the operation and management of network infrastructure including servers, firewalls, switches/hubs, printers/scanners, modems, etc.
12. Serve as the contact person for check out training for technology related equipment (i.e., audio visual equipment, laptop loans, etc.). Assist users in set up of equipment as needed.
13. Serve as backup to other MIS team members when needed.
14. Maintain discretion and client confidentiality at all times.

Education and Experience:
High School Diploma,
A+ Certification and Network+ Certification helpful

I have read, understand and accept the responsibilities outlined in this job description.

Signature:_____ **Date:**_____

Supervisor:_____ **Date:** _____

Family Service Association
101 Rock Street ❖ Fall River, MA 02720
508-678-7542 ❖ www.frfsa.org

Job Description

Position: Director of Quality Improvement
Program: Administration
FLSA Status: Exempt
WCC Code: (8810)
Accountability: The Director of Quality Improvement is directly accountable to the Chief Administration Officer.

Job Summary:
The Director of Quality Improvement is directly responsible for all aspects of the Agency's Quality Improvement Plan and Risk Management activities.

Duties and Responsibilities:

1. Administer, develop, update, coordinate, supervise, and monitor the Quality Improvement Plan.
2. Write, revise and update agency policies and procedures. Provide technical assistance and training for policy and procedure implementation, on both the programmatic and organizational levels.
3. Provide advisement and assistance to all levels of personnel, including leadership, regarding all Quality Improvement initiatives.
4. Administer, develop, update, coordinate and monitor the Agency's Strategic Plan.
5. Administer and monitor the Agency's Risk Management Policies and Procedures (with the exception of Fiscal and Human Resource Risk Management). Advise the President/CEO and other leadership, on all matters relative to Risk Management and Quality Improvement, including development and implementation of appropriate Risk Management strategies in response to identified vulnerabilities.
6. Serve as Chairperson for the Administrative Quality Council at a frequency directed by the Agency's Quality Improvement Plan or in response to organizational needs, including but not limited to Quality Improvement, Compliance, Risk Management, Accreditation and policy development initiatives.
7. Serve as the coordinator of the Agency's accreditation (and licensing as appropriate) preparation and implementation activities and oversee compliance audits as deemed appropriate.
8. Assist leadership with infrastructure development and implementation for new and existing programs and services.
9. Ensure systems and data collection support compliance with evidencing value-based care.
10. Promote wellness via committee structure.
11. Provide training to agency staff and Board of Directors membership on related topics.
12. Serve as the Agency's Privacy Officer and Human Rights Officer.
13. Respond to all reasonable requests of Agency Leadership.

Education and Experience:
Must have a minimum of a Bachelor's Degree in a related field. Demonstrated knowledge and skills related to Quality Improvement/Quality Assurance processes and procedures. Must have strong organizational skills, proven verbal and written communication skills and be technically proficient and competent in computer software and applications. Must have at least 2 years of supervisory experience

I have read, understand and accept the responsibilities outlined in this job description.

Signature: _____ **Date:** _____

Supervisor: _____ **Date:** _____

Revised 3/2012, 3/2014, 4/2016, 6/2017
Reviewed 3/2013, 6/2016

Family Service Association

101 Rock Street ❖ Fall River, MA 02720

508-678-7542 ❖ www.frfsa.org

Job Description

Position: **Director of Client Financial Services**

Program: **Representative Payee & Billing**

FLSA Status: **Exempt**

WCC Code: **(8810)**

Accountability: **The Director of Client Financial Services is directly accountable to the Chief Financial Officer**

Job Summary:

The Director of Client Financial Services is directly responsible to maintain a comprehensive financial management program servicing client needs. The Director of Client Financial Services is responsible for the overseeing and supervision of the Agency Billing Department as well as technical support for the billing and collection of accounts receivable for all programs that are third party billable.

Duties and Responsibilities:

1. Respond to inquiries requesting information on existing services.
2. Handle problem calls from clients when the Supervisor is unavailable.
3. Review deficiency sheets returned from CRR.
4. Review overdrafts and discuss with appropriate Bookkeeper.
5. Provide Rep-Payee Supervisor supervision.
6. Conduct quarterly Quality Management meetings.
7. Attend quarterly agency meetings and monthly Client Record Reviews.
8. Update census and address Utilization Review trends.
9. Review all management and case related problems and changes in policies and procedures with Chief Finance Officer.
10. Review all insurance updates and notify appropriate personnel of changes.
11. Prepare Employee Assistance Program contractual bills as well as manual bills for other programs.
12. Follow-up work for accounts that have been referred to collection.
13. Prepare and process bad debt write-off.
14. Prepare United Way annual report. Analyze wages monthly and report findings to appropriate clinical and fiscal personnel.
15. Attend various seminars and meetings to maintain accurate billing standards and procedures.
16. Prepare and analyze monthly and quarterly billing reports.
17. Prepare other reports as scheduled or directed.
18. Review all fee-for-service invoices before forwarding to Accounting for payment processing.
19. Analyze results of client and customer satisfaction surveys done by C.Q.I.
20. Work with Administrative Assistant to decrease bad debt and improve overall cash flow.
21. Supervise all job functions of the Billing Department and Representative Payee Program.
22. Conduct departmental staff meetings and quarterly training to assure accuracy and consistency in job performance.
23. Prepare annual reviews for all department and staff.
24. Complete staff evaluations, time sheets and vacation requests.
25. Respond to reasonable expectations of Agency and/or Supervisor.

Education and Experience:

High School Diploma is required. Three (3) years' experience in related field. Individual must possess good communication and public relations, financial, and supervisory skills, and ability to deal effectively with diverse groups and individuals.

I have read, understand and accept the responsibilities outlined in this job description.

Signature:_____**Date:**_____

Supervisor:_____**Date:** _____

Family Service Association
101 Rock Street, Fall River, MA 02720
Phone: (508) 677-3822, Fax (508) 677-3714
www.frfsa.org

IMPLEMENTATION TIMELINE – BUDGET PREPARATION PERIOD

TECHNOLOGY ADVANCEMENT

November 1, 2017 – December 31, 2017	January 1, 2018 – March 31, 2018
• Establish contact with Implementation Specialist • Create contact schedule and plan • Create Implementation Team • Identify and notify initial members • Schedule Implementation Team orientation meeting • Determine Team member availability and create meeting schedule for budget prep period • Draft CSA workflow with paper system • Purchase new laptops, prepare for deployment	• Complete IT Manager training on configurable forms and report writing • IT Consultants analyze current paper process and develop electronic workflow • IT Consultant will create configurable forms and develop reports • Test newly created care plan configurable forms and related reports • Prioritize tasks for Implementation Plan • Draft Implementation Plan (work plan) and distribute for feedback • Finalize Implementation Plan • Gather data needed for care plan entry • Deploy new laptops to all ICCs

WORKFORCE DEVELOPMENT PLAN

November 1, 2017 – December 31, 2017	January 1, 2018 – March 31, 2018
• Create FSA team for training • Assess current staff knowledge of Wraparound processes • Draft training modules for Tier 1 and Tier 2 credentialing • Begin collaboration with Southeast region CSAs for creation of shared learning/training resource library	• Finalize training modules for Tier 1 and Tier 2 credentialing • Create presentation tools – i.e. posters, Power Point slides, etc. • Create written materials to be used in support of training – i.e. handouts, fact sheets, quizzes, etc. • Complete shared learning/training resource library

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www.frfsa.org

IMPLEMENTATION TIMELINE – YEAR ONE

TECHNOLOGY ADVANCEMENT

April 1, 2018 – June 30, 2018	July 1, 2018 – Sept. 30, 2018	Oct. 1, 2018 – December 31, 2018
• Train staff on care plan format and functionality • Collect data and begin entry of existing Care Plans • Design electronic workflow to meet quality measures and how measured will be mapped to EHR • Establish MiFi service accounts to support mobile access to EHR • Continue to develop, test edit and implement all configurable forms and reports	• Monitor care plan entry to ensure consistency • Train support staff on EHR and begin entry of care plans • Develop/update FSA policies for mobile technology including MiFi use, submit policy for approval • Continue to develop, test, edit and implement all configurable forms and reports • Develop training materials for end users and report writers	• Document CSA workflow with current paper system as compared to new electronic process • Prioritize tasks for full Go-Live Implementation • Continue to test, edit and implement all configurable forms and reports. • Finalize all training documents and process for roll-out • Train staff on MiFi use and related policy

WORKFORCE DEVELOPMENT PLAN

April 1, 2018 – June 30, 2018	July 1, 2018 – Sept. 30, 2018	Oct. 1, 2018 – December 31, 2018
• Begin staff education for Tier 1 Wraparound Credentialing for first cohort (all staff employed for greater than six months)	• Provide Tier 1 modeling and coaching for first cohort • Being staff education for first Tier 2 cohort (all staff who previously achieved Tier 1)	• Monitor fidelity and provide additional coaching for skill development for first Tier 1 cohort • Begin education modules for second Tier 1 credentialing cohort • Finalize Tier 1 credentialing for first cohort • Provide Tier 1 modeling and coaching for second cohort • Begin modeling and coaching for first Tier 2 cohort

Family Service Association
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www.frfsa.org

IMPLEMENTATION TIMELINE – YEARS TWO TO FIVE
2019 – 2022
TECHNOLOGY ADVANCEMENT

Jan. 1 – Mar 31	Apr 1 – June 30	July 1 – Sept 30	Oct 1 – Dec
• Implement complete EHR (2019) • Begin regular reporting on quality measures (2019) • Confirm all forms are operating correctly and confirm accuracy of all reports (2019) • Continue MiFi service to support mobile access to EHR (2019 and 2020) • Draft work plan for conversion to Carelogic Mobile (2020 only) • Maintain support for use of Carelogic Mobile (all of 2021 and 2022) • Begin research for use of the MassHIway. Assess capacity to exchange data with area providers including PCPs and ACO/MCO (2021 only) • Continue implementation of work plan for MassHIway use and secure data exchange (2022 only)	• Monitor to ensure consistent and timely entry (2019) • Finalize work plan for conversion to Carelogic Mobile (2020 only) • Begin reconfiguration of forms to support access to Carelogic Mobile (2020 only) • Continue research for use of the MassHIway and to support secure data exchange with providers (2021 only) • Draft work plan to respond to research findings, including plans to use MassHIway and to ensure secure data exchange with providers (2021 only) • Test MassHIWay access and secure data exchange functionalities (2022 only)	• Test forms and service dcouments for conversion to Carelogic Mobile. Establish "go live" date (2020 only) • Finalize work plan to respond to research findings, including plans to use MassHIway and to ensure secure data exchange with providers (2021 only) • Train staff on use of MassHIWay (2022 only)	• Complete conversion to Carelogic Mobile (2020 only) • Discontinue MiFi service (2020 only) • Being implementation of work plan for MassHIway use and secure data exchange (2021 only) • Complete access/use of MassHIWay and secure data exchange. Complete updates to all related policies and ensure all staff are trained on policy changes (2022)

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www.frfsa.org

IMPLEMENTATION TIMELINE – YEARS TWO TO FIVE
2019 – 2022
WORKFORCE DEVELOPMENT PLAN (WDP)

Jan. 1 – Mar 31	Apr 1 – June 30	July 1 – Sept 30	Oct 1 – Dec
• Continue to create cohort groups for Tier 1 and Tier 2 credentialing • Continue to provide modeling and coaching as staff progress through stages of credentialing • Begin planning for Motivational Interviewing (MI) Training (2019 only) • Begin planning for Coaching in Collaborative Problem Solving (CPS) training (2020 only) • Identify staff to attend National Wraparound Implementation Academy • 3 additional staff complete CPS training (2021 only) • Research additional training and certification options to advance WDP (2021 and 2022)	• Continue to create cohort groups for Tier 1 and Tier 2 credentialing • Continue to provide modeling and coaching as staff progress through stages of credentialing • Complete Tier 1 and Tier 2 credentialing for all staff hired prior to May 2017 • Schedule Introduction to Motivational Interviewing for all staff • Identify five staff to progress to MI Certification (2019 only) • Identify five staff to complete Tier 1 Certification in CPS (2020 only) • Identify 2 staff to complete Tier 1 Certification in CPS (2021 only) • Deploy additional training programs	• Continue to create cohort groups for Tier 1 and Tier 2 credentialing • Continue to provide modeling and coaching as staff progress through stages of credentialing • Schedule and deploy Trauma-Informed Care training for all staff. This training will be offered again in year 3.	• Continue to create cohort groups for Tier 1 and Tier 2 credentialing • Continue to provide modeling and coaching as staff progress through stages of credentialing • Develop training plan for certified MI staff to train additional staff (2019 only) • Plan and train new staff on MI (2020 and 2021 only) • Two staff complete training at National Wraparound (2019 only) • Implementation Academy • All staff complete CPS training (2020 only) • Five staff complete CPS certification (2020 only) • Two staff complete CPS certification (2021 only) • Complete additional training programs (2021 and 2022)

ATTACHMENT B: CSA BUDGET REPORT TEMPLATE

CSA Budget Report

	Family Service Asscoiation							
Budget	**Estimated Members Supported (Monthly Average)**	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
Prep Period		$ 125,772						
Budget Year 1			$ 63,945					$ 63,945
Budget Year 2				$ 60,900				$ 60,900
Budget Year 3					$ 36,540			$ 36,540
Budget Year 4						$ 24,360		$ 24,360
Budget Year 5							$ 12,180	$ 12,180
TOTAL FUNDS								$ 197,925

Budget Allocation	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Workforce Development							
Salaries	$ 4,117	$ -	$ -	$ -	$ -	$ -	$ -
Taxes and Fringe	$ 1,060	$ -	$ -	$ -	$ -	$ -	$ -
Training	$ 5,000	$ 12,000	$ 22,900	$ 10,991	$ 7,072	$ -	$ 52,963
Operational Infrastructure							
Salaries	$ 26,279	$ 27,867	$ 22,632	$ 10,759	$ 10,075	$ 6,386	$ 77,720
Taxes and Fringe	$ 7,366	$ 7,523	$ 7,488	$ 3,590	$ 3,213	$ 2,044	$ 23,857
Consultants	$ 58,400	$ 5,950	$ 5,000	$ -	$ -	$ -	$ 10,950
Recruitment	$ -	$ 450	$ -	$ 500	$ 500	$ 250	$ 1,700
Technology							
Consultants	$ 12,750	$ 7,275	$ -	$ 7,200	$ -	$ -	$ 14,475
Equipment-Laptops, MIFI's, and Carelogic Mobile App	$ 10,800	$ 2,880	$ 2,880	$ 3,500	$ 3,500	$ 3,500	$ 16,260
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL INVESTMENTS							$ 197,925

Sharon E. Ford

224 East Main Street, Middleborough, MA 02346
508 / 946-4709

Summary of Qualifications

- Proven ability to successfully manage Division of Medical Assistance (DMA) programs with extensive knowledge of DMA reporting requirements
- Experience in developing, implementing and monitoring indicators and other performance measures
- In-depth understanding of all practices as they apply to the preauthorization, implementation and overall programmatic requirements of service provision
- Adept at establishing a diverse network of certified agencies, service providers, community organizations, and accreditation boards including the Council on Accreditation for Children and Family Services and the Division of Medical Assistance, to ensure programmatic success
- Excellent organizational, communication and decision making skills
- Strong commitment to cooperative teamwork
- Versatile and adaptable; welcome the challenge of solving problems while managing numerous projects concurrently

Professional Experience

Family Service Association of Greater Fall River, Inc. 1992- Present

- Chief Program Officer – Responsible for planning, organizing, and overseeing all activities of the organization's programs and collaborates with the President/Chief Executive Officer for the overall administration of the agency. Directly responsible for the development, management, and quality improvement activities of all programs: Specialized Adult, Youth, and Clinical. Functions as an integral member of the Senior Leadership team, and is responsible for all agency activity in the President's absence. Responsible for the management of organizational activities that ensure a high level of quality commensurate with the mission of the organization and interests of the Board of Directors, clients, employees, and other stakeholders. Responsible to clearly communicate current information regarding community needs, industry trends, and changes in the regulatory environment to the Chief Executive Officer.

- Vice President of Elder & Social Services Directly responsible for the development, management and quality improvement activities of four Adult Day Health Programs, Adult and Group Foster Care Programs, Guardianship Program and the Lives in Forward Transition Program.

- Program Manager
  Home Assistance Program (1998 to 2004)
  Develop, supervise and manage of all aspects of the program

- Social Worker
  Adult Family Care (1992 to 1998)
  Evaluate potential participants and foster families, monitor placement, and provide on-going case management

South Shore Elder Services, Inc.

- Protective Service Worker (1986 to 1992)
  Investigate reports of elder abuse, develop individualized service plans and provide on-call crises management

- Case Manager (1984 to 1992)
  Assess and monitor frail elders for home care services

Stetson Manor Nursing Home

- Social Worker (1984 to 1986)

Norwell Council on Aging

- Outreach Coordinator (1983 to 1984)

Education

- Framingham State College – MA Public Administration 1992

- Fitchburg State College – B.A. in Human Services 1983

Licenses

- Licensed Social Worker 1990 – License Number 3019873

- CPR Certified

SHARON LAFLEUR, MSW, LICSW
2 MAPLE AVENUE
FAIRHAVEN, MA 02719

WORK EXPERIENCE:

Family Service Association, Fall River, Ma 02720

Program Director-Children's Behavioral Health Services 04109-present

- Implement and manage Intensive Care Coordination and Family Support and Training services for the Fall River Community Service Agency.

Program Manager -LIFT 10107-7110

- *Manage an Intensive Foster Care program for transition age youth.*

Program Manager - Child *& Youth Specialty Services 11198-4109*

- Supervision of master's level clinicians providing individual, group and family therapy to adolescent residents at St. Vincent's Home.
- Provide individual, group and family therapy services to residents at St. Vincent's Home.
- Conduct individual, family, sexual abuse, substance abuse, firesetting and offender assessments.
- Participate in clinical team meetings.

Saint Anne's Hospital, Fall River, MA 02721

Clinical Social Worker-Teen Violence Program 02198 – 11198

- Supervision of master's level social work students providing individual, group, and family therapy to adolescents who have been impacted by violence.
- Provide therapy to traumatized adolescents.
- Provide individual and family therapy to parents and siblings of adolescents who have been victimized by violence.
- Facilitate treatment group for adolescents who have witnessed violence in their home.
- Outreach to community agencies and resources to educate and provide information with regard to teen violence resource program.
- Provide trainings to local schools and agencies with regard to childhood physical and sexual abuse.

Clinical social worker - Pediatric Sexual Abuse Program *02194 – 11198*

- Supervision of clinical social workers and master's level social work students providing evaluations, individual, group, and family therapy for victims of sexual abuse.
- Provide APSAC sexual abuse assessment training to local community agency and master's level social work students.
- Provide therapy for children and adolescent victims of sexual abuse.
- Provide individual and family therapy to parents and siblings of child victims of sexual abuse.
- Conduct sexual abuse assessments adhering to APSAC guidelines.
- Co-lead treatment group for adolescent and latency-age victims of sexual abuse.
- Perform case management duties including collateral contacts, referrals for psychological testing and pharmacological consults.
- Provide 24-hour social work coverage to the emergency department and hospital for crisis situations on a rotating schedule.
- Conduct psychosocial assessments, provide support, crisis counseling, and referrals to appropriate resources for hospital patients and their families.
- Participate in Employee Assistance Network, counseling hospital employees upon request, providing short-term consultation and referral to appropriate resources.

Center for Health & Human Services, Fall River, MA

Clinical Social Worker *05193-03197*

- Provide therapy for children and adolescent and adult victims of sexual abuse.
- Provide home-based, school-based, and outreach counseling services to at-risk families and children.
- Perform case management duties including collateral contacts, referrals for psychological testing and pharmacological consults.
- Co-lead treatment group for adolescent victims of sexual abuse.
- Conduct sexual abuse assessments adhering to APSAC guidelines.

Suffolk County District Attorney's Office, Boston, MA

Senior Victim Witness Advocate *02185-05193*

- Coordinated services for child sexual and physical abuse cases.
- Interviewed child victims for determination of testimonial competency and trial preparation.
- Oriented victim/witness to the Criminal Justice System.
- Assisted victims and witnesses with the anxiety of providing testimony.
- Assessed the social service needs of the victim and referred to existing community agencies.

EDUCATION

- Master's Degree of Social Work — *09190* – 05/93
  Boston University, Boston, MA — Clinical Major, G.P.A. 3.78

- Bachelor of Science Degree in Criminal Justice — 09/81 - 05/84
  Northeastern University, Boston, MA — Magna Cum Laude; Dean's List

- Alpha Phi Sigma (National Criminal Justice Honor Society)

References Available Upon Request

Katherine Kasheta

E-Mail: katkasheta@yahoo.com
735 Willett Ave, Unit 905
Riverside, RI 02915
(401) 632-4514

Education

Boston University — Boston, Ma
Master of Social Work — May 2006
GPA 3.44

Roger Williams University — Bristol, RI
Bachelor of Arts in Psychology — May 2003
Minor in Creative Writing and Sociology — GPA 3.1

Work Experience

Newport County Community Mental Health Center — Middletown, RI
Outpatient Therapist — February 2007 - Present

- Provide individual and family therapy to client and their families.
- Develop individualized treatment plan for clients.
- Prepare progress notes for individual and family therapy.

Newport County Community Mental Health Center — Middletown, RI
Children's Intensive Services Clinician — June 2006 -Present

- Conduct individual and family therapy for clients.
- Plan and lead weekly groups for adolescents ages 13-18.
- Provide crisis assessments and intervention to client and their families.
- Maintain medical record documentation including progress notes for individual, family and group therapy.
- Develop individualized treatment goals for each client addressing key areas identified in the assessment.

Newport Connty Community Mental Health Center — Middletown, RI
Independent Living Apartment Program Case Manager — November 2005 - June 2006

- Provide case management services to young adult women.
- Assist the young women in developing and working towards their treatment goals.
- Provide assistance and support in learning independent living skills.
- Utilize crisis intervention, stabilization and counseling techniques.
- Advocate for clients.

Barnes & Noble — Middletown, RI
Cafe Server — 2003 -November 2005

- Perform accurate cash and credit card transactions daily.
- Perform opening and closing procedures.
- Answer customer inquiries in and informative and friendly way.
- Prepare drinks and food daily.
- Ensure overall cleanliness of the cafe.
- Train new employees.

Internship Experience

Mt. Hope High School. Bristol, RI
MSW intern September 2005 - May 2006

- Conduct individual therapy for students.
- Plan and lead groups for students.
- Prepare process notes for individual and group therapy.
- Attend IEP meetings, 504 meetings, evaluation team meetings and parent meetings.
- Prepare Social Histories of students.

Newport County Community Mental Health Center Middletown, RI
MSW intern September 2004 - May 2005

- Assist group leaders with CIS middle school aged groups.
- Conduct individual therapy for outpatient clients.

- Plan and lead an ADHD group for middle school aged children.
- Prepare process notes for individual and group therapy.

Emily J. Kelleher

90 Wolcott Avenue Middletown, RI 02842 (401) 263-3314

Education/ Licensure:

Rhode Island Board of Health - Providence, RI

* Licensed Mental Health Counselor (LMHC) - October 21, 2006
  License # MHC00311 expires July 1, 2014

Salve Regina University - Newport, RI

* Certificate of Advanced Graduate Studies (CAGS) in Mental Health Counseling - May, 2006
* Graduate Certificate in Expressive Arts (GCEA) - May, 2005
* Masters of Arts (MA) in Holistic Counseling – May, 2002
* Bachelor of Arts and Science (BAS) in Psychology and Social Work – May, 1996
  * Psi Epsilon Delta
  * Magna Cum Laude

RI Department of Mental Health, Retardation and Hospitals - Providence, RI

* Division of Integrated Mental Health Services:
  Certified Community Support Professional (CCSP) - June, 1998

Professional Experience:

Newport Country Community Mental Health Center CNCCMHC) – Middletown, RI

* *Children and Adolescent Treatment Services:* provide clinical supervision to therapists, case managers and student interns; diagnostic assessments; treatment planning; conduct individual, family and group therapy sessions within home, schools, office/milieu program; obtain authorization for intensive clinical services from insurance companies

  Children's Intensive Services (CIS) Program Coordinator: December, 2008 -Present
  Early Childhood Day Treatment Therapist: October 2012 - Present
  Outpatient Therapist: October, 2006 - Present
  - CIS Team Leader: November, 2003 – December, 2008
  CIS Therapist: November, 2002 - Present
  CIS Acting Program Coordinator: December, 2004- May, 2006
  School Based Outreach Therapist: August, 2002 -November, 2002

* *Anita Jackson House Group Home:* case management services for chronic mentally ill adults including representative payee services, psychoeducation, medication monitoring
  Residential Case Manager: July, 1997- August, 2001
  Residential Counselor: June, 1996- July, 1997
  Relief Residential Counselor: June, 1995 - July, 1997

* *Phoenix One Day Treatment Program:* rehabilitative counseling for chronic mentally ill adults including psychoeducational groups
  Relief Rehabilitation Counselor: August, 1996- July, 1997

Internships/ Volunteer Work:

NCCMHC -Middletown, RI
* *Adult General Outpatient Department:* October, 2001- May, 2002

Women and Infants Hospital - Providence, RI
* *Kids Klub Program:* for siblings of premature babies
  September, 2001- May, 2002

Newport Hospital – Newport, RI
* *Mental Health Unit/Social Work Department:* September, 1995- May, 1996

Greene Lane Group Home - Middletown, RI
* *Residential Counselor/ Case Manager:* January, 1995- May, 1995

Heatherwood Nursing Home -Newport, RI
* *Activities Department:* September, 1993- February, 1994

Linden Elementary School - Middletown, RI
* *Developmentally Delayed Pre-school Class:* January, 1991- June, 1991

Child and Family Services - Middletown, RI
* *Day Care Center Toddler and Pre-school Rooms:* June, 1989- August, 1989

May 4, 2014

References for Emily J. Kelleher, LMHC

Gary Cournoyer, LICSW

Previous supervisor – CIS Administrator

401-842-1158

Sara Purnell, PMHCNS

Clinical Nurse Specialist

401- 919-1656

Shannon Duggan, LMHC

Therapist-supervisee

401-662-9481or 401-848-6363 x142

49 Barry Avenue
Somerset, Massachusetts, 02726
cell (774) 319-8291
ljbmahoney@gmail.com

Lori JB Mahoney

Professional Experience

Chief Administration Officer, 2016-present
Family Service Association, Fall River, Massachusetts
Oversight of all activities of agency support services and collaboration with the President/Chief Executive Officer for the overall administration of these departments. Development, management, and quality improvement activities of Human Resources, Information Technology, Marketing, Quality Improvement, and Facilities.

- Oversaw redesign for IT department structure to hybrid model, including impetration of plan to improve infrastructure to mitigate operational and security risk.

Director, Human Resources, 2014 – 2016
Family Service Association, Fall River, Massachusetts
As a collaborative member of the Leadership Team, provide HR guidance and consultation to a mission-drive family service agency with 350 employees. Oversee all areas of Human Resources, including employment, performance management, employee relations, compensation and benefits, and safety.

- Improved recruitment process by implementing automated Applicant Tracking System and increasing professional recruitment assistance to hiring managers.
- Working cooperatively with leadership to restructure several departments, eliminating unnecessary positions with relatively low unemployment
- As Safety Committee chairperson, modified employee injury reporting to include incident follow-up procedure and near-miss reporting. In 2015, lost work days claims cost decreased by over 50%, partially due to robust modified duty program.

Director, Human Resources, 2004 – 2014
Southcoast Hospitals Group, Southcoast Physicians Group, New Bedford, Massachusetts
As an active leadership partner, continuously enhance HR contributions to multi-service, acute care hospitals and physician practices with over 6,500 employees.

- Partner with Care Center Division leaders workforce planning, performance improvements, and employee engagement strategies.
- Oversee and deliver high quality HR services, including employment, employee relations, performance management, training, and program implementation.
- Lead HR team of eight professional and administrative staff toward various operational improvements to improve quality and increase efficiency of HR services.
- Lead Employment Process Automation Team, resulting in improved service, efficiency, and customer satisfaction.

- Resolved highly complex employee relations issues with tact and respect while minimizing legal exposure. Despite high volume and complexity of issues, 100% of cases were resolved internally in four consecutive years.
- Source, recruit, interview, and hire various "hard-to-find" professionals, and develop interviewing and selection skills of client partners.
- Actively contribute to several cross functional HR teams e.g., turnover, performance improvement, policy revision, HRIS, and cultural initiative program
- Design and administer various training programs. (eg. performance management, new employee orientation, leadership, etc.).
- Successfully use of the Predictive Index tool in recruitment, on-boarding, and individual and group leadership development.

Corporate Human Resource Manager, 1998 - 2004
Diocesan Health Facilities, Fall River, Massachusetts
As a member of the corporate management team, worked cooperatively to establish progressive HR function to assist the organization in providing innovative, comprehensive long-term health care.

- Managed all HR programs in 1200 employee, multi-facility organization.
- Provided coaching to HR staff of 11, in 5 locations, and cooperatively establish and implement HR development plan.
- Managed HR/payroll/attendance software conversion on citrix network for multiple locations, including overseeing vendor selection process, set-up, training, and implementation across all departments, including policy and procedure development and implementation.
- Oversaw wage and salary administration, and train managers regarding strategy and implementation.
- Provided guidance and consultation to facilities in all issues regarding safety management, including monitoring worker's compensation claims and OSHA compliance.
- Provided system-wide managerial training in various HR issues, including employee screening and selection, performance management, sexual harassment, incident investigation, and compliance.

Human Resource Director 1994-1998
Madonna Manor (a Diocesan Health Facility), North Attleboro, MA

- Responsible for all functions of Human Resource Department in 180 employee facility.
- Screened, selected, and provided orientation training for all new employees.
- Consulted with department managers on all employee relations matters
- Responsible for compliance with state and federal law, as well as various other state long-term care regulations.
- Oversaw payroll and benefits administration, including unemployment and disability claims management.
- Managed conversion of employee benefit to Paid Time Off system.

- As Safety Committee Chairperson, oversaw all aspects of Safety Management Program, including aggressively managing all workers compensation claims and OSHA compliance.
- Provided training to employees in various human resource issues, including sexual harassment and safety awareness.

Education

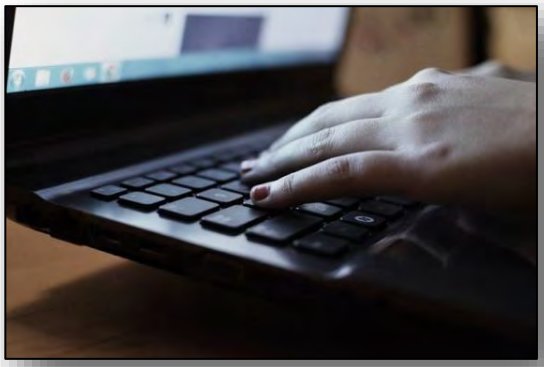
Master of Business Administration - Salve Regina University	HR Concentration
Bachelor of Science - University of Massachusetts at Amherst	Major - Psychology
Professional in Human Resources Certification (PHR)	1993 - 2011

Skills/Attributes

- Strong verbal and written communication skills
- Trained CQI facilitator with solid negotiation skills
- Proficient in MS Office, and several s applicant tracking and payroll systems
- Strong presentation skills. Experienced HR/Management skills trainer
- Member of the Society of Human Resource Management and Northeast Human Resource Association

Thank you for choosing Qualifacts (QSI) as your new electronic health records partner. The Qualifacts Implementation Team would like to welcome you to the CareLogic community.

Over the course of the next few months, your Qualifacts project manager (PM) and implementation specialist (IS) will guide you through the configuration, testing, and deployment of CareLogic to best meet the needs of your agency. This process will consist of understanding your current business processes (workflows) and assisting you in the translation of these into a best practice future business processes (workflows) setup within CareLogic in order to maximize efficiencies in both consumer care and revenue lifecycles.



Your dedicated Implementation Specialist is the CareLogic software subject matter expert assigned to the project. The IS will be responsible for system training and configuration guidance on how to setup CareLogic to best meet the agency's business needs.

The Implementation Specialist has an in-depth knowledge of the product and industry standards. The primary goal is to establish successful relationships with the customer and their use of the product presents opportunities beyond standard customer support. Some of these areas include assessments, recommendations on best-use cases, and more complex needs of the product. Responsibilities of the IS include:

- Establishing stronger relationships with Executive CareLogic sponsors at the agency
- Measuring customer satisfaction, reference ability, and effective use of the system
- Project meeting facilitation
- Project plan maintenance
- Manage staff to task completion per timeliness in customer project plan
- Status meeting agendas/minutes and other project controls
- Liaison between customer project team and QSI project team – handling logistics and communication
- Issues resolution
- Identifies and manages trainers for the project
- Oversees issue management for the project

TINA KIRKPATRICK – Information Specialist

PROFESSIONAL EXPERIENCE:

Customer Success Manager/Implementation Specialist
Qualifacts Systems Inc - Jan 2015 to Present

Manager of Implementation
Qualifacts Systems Inc - Aug 2013 to Dec 2014

Project Manager
Qualifacts Systems Inc - June 2009 to Aug 2013

Director of Implementation and Training
CRC Health Group - Sep 2004 to June 2009

Billing Manager
Genesis HealthCare - November 1996 to September 2004

EDUCATION:

AIU (American InterContinental University)
BA, Business Management, Healthcare Administration

Angela J. Spellman
149 Grant St., Fall River, Massachusetts 02721 **(508) 567-7013**
angela.obrien823@gmail.com Linkedin profile: www.linkedin.com/in/ajobrien/

1/2000 – Present, Family Service Association of Greater Fall River, Inc., Fall River, MA

2017 – Present
Manager of Information Technology

- Provide leadership to IT Staff
- Design, organize, maintain and support all matter of information management, application of technology, and connectivity for all FSA locations.
- Responsible for the oversight of the EMR, including full implementation, planning, design, training, support and maintenance.
- Manage staff, equipment and expense associated with FSA's IT functions.
- Collaborate with consultants to identify areas where change, use or increased use of automated systems would provide increase speed, accuracy or efficiency in agency operations.
- Provide technical expertise to Senior and Program Leadership.
- Develop business case justifications and cost/benefit analyses for Information Technology spending and initiatives. Lead acquisition of technology inclusive of computers, phones, copiers and other technological systems.
- Manage technology inventory (hardware and software) to include procurement, installation, configuration, recordkeeping and disposal.
- Establish service level agreements with internal and external customers and service providers and monitor service delivery to ensure the agreed targets and standards are met.
- Assist with all aspects of the implementation of new applications and modules as it relates to Electronic Medical Records. Lead all aspects of new program implementation. Development, implementation and maintenance of new forms by program into the system.
- Assist with EMR training and education of software upgrades, new features and new functionality. Responsible for troubleshooting and completing application issues and trouble tickets (Soffront and CLHelp), and reporting to the software vendor.
- Act as Chairperson of the Carelogic Improvement Team, as well as a liaison to the all users and leadership in order to ensure that all issues are resolved in a timely manner. Provide consultant level support and on the job coaching and mentoring for all users as needed
- Assist with the advancement of clinical applications, interfaces, data migration and reporting of the EMR software. Provide administrative reports as requested by Leadership.
- Assist with the creation of policies and procedures for all IT areas, including EMR processes and workflows.

2015 – 2017
EMR Project Manager

- Lead all aspects of new program implementation, continuing development and enhancement of EMR system.
- Develop and maintain a training curriculum, schedule and instruct clinical and non-clinical staff on the appropriate use of EMR system.

- Schedule and assist with training and education of software upgrades, new features and new functionality.
- Act as a liaison between staff and EMR vendor in order to ensure that all issues are resolved appropriately.
- Provide support, coaching and mentoring for all users as needed.
- Responsible for troubleshooting application issues and handling internal trouble tickets.
- Assist with the advancement of clinical applications, user interfaces, data migration and reporting in the EMR software.
- Create policies and procedures for EMR processes and workflows.
- Provide administrative reports as required, including regular reporting of key performance indicators to leadership using SQL based tools and software.
- Perform all duties related to the management and supervision of the Information Technology Department and its staff.

2001 – 2015
M.I.S. Supervisor/HIPAA Security Officer

- Developed and documented policies and procedures for all MIS/IT related functions.
- Ensured the security and confidentiality of all electronically stored client information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Performed all duties related to the administration of an enterprise level network serving over 400 users across 19 locations.
- Served on the HIPAA Implementation Team as Technology and Security Officer.
- Supervised MIS Technicians and Assistants.
- Purchased, installed and maintained all IT related equipment (hardware/software/accessories)
- Negotiated contracts for all IT and telephone related services.
- Administered telecommunications services and equipment for all sites.
- Worked closely with all agency staff, including managers, senior leadership and board of directors.

Education:
9/1987 Massasoit Community College, Brockton, MA
Liberal Arts - Science Option
6/1995 Kinyon and Campbell Business School, Brockton, MA
Vocational - Legal Support Worker
6/1997 Computer Training Specialists, II, Fall River, MA
Certification

Attachment C: CSA Budget Narrative

Budget Expenses:

(Investment narrative should only include investments listed in the Budget Report provided on Attachment B. Please provide separate descriptions of budget allocations for each project)

Workforce Development **Total:** $ 63,139.55

In the box below, please provide a description of all items within the Workforce Development investment category (e.g. recruitment support, training and coaching programs and certifications). Please be sure to specify the goals and project(s) this investment will support, as described in **Section 3.4** and **Section 6** of the RFR and how these investments will assist in meeting the terms of the Contract.

Prep Budget Workforce Development Plan Investments:

The activities in the Prep Budget period for the Workforce Development Plan investments support the goal of strengthening fidelity to Wraparound processes, including care planning, care coordination and care management. These activities will improve the CSA's capacity to provide quality services, promote member engagement while adhering to the ten principles of Wraparound and ensure timely access to services.

National Wraparound Model Credentialing:

- Develop team for training project
- Assess current staff knowledge of Wraparound processes
- Design training modules for Tier 1 and Tier 2 including creation of all required training materials

Total of 125 hours - $4116.75
Fringe – FICA, Unemployment, Workers Compensation, Pension and Health Insurance for all staff- $ 1,059.80

Training Resource Library:
Family Service Association's CSA will reserve $5,000.00 to participate in the development of a Training Resource Library that will be shared by the CSAs in the Southeast region. Preliminary conversations have occurred to foster this regional collaboration. The project will develop further with the support of capacity funding which will support staff time, travel and resources needed to create library content. If the regional collaboration with other does not occur we will apply the funds to the creation of an FSA Training Resource Library. Materials will ongoing support, education and training on CBHI and CSA services, strength-based practice models that foster fidelity to Wraparound processes and member engagement. Materials will be used to train FSA staff and to promote team building and collaboration with community entities such as other providers, ACOs, MCOs and primary care providers.

Year 1 Budget Workforce Development Investments:

The activities in the Year 1 Budget Period for the Workforce Development Plan continue to support the goal of strengthening fidelity to Wraparound processes by building and further advancing the skills of the CSA staff.

Wraparound Credentialing Implementation: Wraparound credentialing will begin for Tier 1 and Tier 2 for all staff employed longer than 6 months. Certified Wraparound Coaches will train staff on each module, followed by modeling and coaching as needed. Every staff member will complete Tier 1 Wraparound credentialing by the end of this budget period. Staff who have already achieved Tier 1 Wraparound credentialing will complete Tier 2 credentialing.
Tier 1: 24 staff @ $300 = $7,200.00
Tier 2: 8 staff at @ $600 = $4,800.00
Total: $12,000

Years 2-5 Budget Workforce Development Investments:

The activities in budget years 2-5 of the Workforce Development Plan continue to support the goal of strengthening fidelity to Wraparound processes. As staff complete training and achieve credentialing and/or certification in key areas, they become eligible to serve as educators, further advancing their expertise and ensuring the sustainability of these investments.

Additional Wraparound Credentialing (2019): Staff completing Tier 1 credentialing in budget year one will complete Tier 2 Wraparound credentialing in year two.
2019 - 24 staff achieve Tier 2 @ $600 = $14,400.00

Motivational Interviewing (2019): Certification in Motivational Interviewing (MI) will be provided through the University of Massachusetts Medical School Center of Integrated Primary Care on-line certification program. All staff will complete the introduction to Motivational Interviewing. Five additional staff with complete the Intensive Training in Motivational Interviewing; which includes Healthcare Behavior Change and Motivational Interviewing, Defining Motivational Interviewing, Spirit of Motivational Interviewing, Complex Reflections and Empathy, Change Talk and Sustain Talk, Responding to Sustain Talk and Discord, The Four Processes of Motivational Interviewing, Change Planning and Motivational Interviewing Theory and Evidence.
Introduction to MI @ a cost of $2,500.00
Intensive Training in MI Certificate Course: 5 staff @ $600 = $3,000.00
Total: $5,500.00

Trauma Informed Care (2020): Training will be provided by Clinical & Support Options. Topics covered in the the Trauma Informed Care training include Positive Parenting and Behavior Management, Parenting Your Traumatized child and Attention Deficit Hyperactivity Disorder.
$200 per hour x 4 hours with an additional four hours for travel
Total: $1,600.00

National Wraparound Implementation Academy: FSA will send two staff to the annual conference at the National Wraparound Implementation Academy to build knowledge, develop skills and advance expertise in Wraparound. The Academy will include new sessions focused on system and practice issues facing Wraparound initiatives and practitioners.
2 staff @ $1500
Total: $ 3,000.00

Collaborative Problem Solving (2020): Coaching in Collaborative Problem Solving will be offered by Think:Kids and the Department of Psychiatry at Massachusetts General Hospital. The introductory training will provide a means to understand and help children who struggle with behavioral challenges. Five additional staff will complete Intensive Training in this evidence-based approach to aiding adolescents with behavior challenges.
Introductory Training: 34 staff @ $149 = $5,066
Intensive Training: 5 staff @ $625 = $3,125
Total: $8,191.00

Collaborative Problem Solving (2021): Three additional staff will complete the introductory training, two additional staff will complete the Intensive Training and two staff will complete Advanced Training.
Total: $5,572.00

Additional Wraparound Credentialing (2020-2021): New staff will begin Tier 1 in their first year of employment and advance to Tier 2 of Wraparound credentialing in the second year of employment

2020 – additional credentialing for new staff = $1,200.00
2021 – additional credentialing for new staff = $1,500.00
Total: $2,700.00

Operational Infrastructure **Total:** $ 206,272.45

In the box below, please provide a description of all items within the Operational Infrastructure investment category (e.g. system change resources, performance management capabilities and additional operational support). Please be sure to specify the goals and project(s) this investment will support, as described in **Section 3.4** and **Section 6** of the RFR and document how these investments will assist in meeting the terms of the contract.

Prep Budget-Operational Infrastructure Investments:

The goal of Operational Infrastructure Investments is to improve organizational capacity to access real-time data to support data-driven decision-making to improve the quality of CSA delivered services. Armed with contemporary information, the program can continually respond to data changes and trends, ensure timely access to services and foster member engagement. These investments will also improve options for family, providers and primary care providers to have a virtual presence at care plan and team meetings using mobile communications.

IT Manager will be responsible for collaborating with consultants to provide oversight of the implementation plan. The IT Manage will chair Implementation Team meetings and participate in comprehensive individualized training on the development, testing and deployment of configurable forms and specialized report writing.
880 hours @ 33.43
Total: $14,709.20

IT Consultants will analyze current paper process, develop electronic workflow and work collaboratively with internal FSA resources
560 hours @ $50
Total: $28,000.00

IT Consultants to draft EHR configurable forms, test and edit drafts and implement final versions of all forms required to support CSA services.
560 @ $50
Total: $28,000.00

Clerical Staff will provide support to CSA during EHR transition; collect data in preparation for data entry, complete some data entry to transition paper records to complete electronic record
462 hours @ $14.10
Total: $ 6,514.20.

CSA Supervisor to take on additional role as EHR Champion; charged with coaching CSA staff on EHR workflow and use, coordinating training, and troubleshooting with IT Manager and Consultant.
82 hours @ 28.66
Total: $2,350.12

Director of Children's Behavioral Health Services to assume additional responsibilities for oversite of the EHR implementation and resultant changes in work flow
19 hours @ 52.71
Total: $1,001.49

Director of Quality Improvement will consult with Implementation Team to ensure the quality measures meet FSA QM standards and practice.
22 hours @ $42.00
Total: $924.00

Director of Client Financial Services will consult with Implementation Team to ensure the billable interfaces align with existing workflows
20 hours @ $39.00
Total: $78.00

Fringe: FICA, Unemployment, Workers Compensation, Pension and Health Insurance for all staff
Total: $7,366.44

Consultant: Qualifacts Consultant Project Manager will provide training in advanced report writing for IT Manager
16 hours @ $150. 00 per hour
Total: $2,400.00

Year 1 Budget-Operational Infrastructure Investments:

The goal of these Operational Infrastructure Investments is to further improve organizational capacity to access information and support data-driven decision-making to improve the quality of CSA delivered services. These investments ensure appropriate staffing levels with the least possible disruption of services during the EHR transition.

Clerical Staff: Clerical staff will provide support to the program; collect data in preparation for data entry, complete some data entry to establish complete electronic records for existing enrolled families.
640 hours @$14.10
Total: $9,024.00

CSA Supervisor: One CSA Supervisor will take on additional role as EHR champion in support of implementation, workflow changes, staff training and troubleshooting with IT Manager and Consultants.
123 hours @$29.52
Total: $3,630.96

Human Resources: Recruitment costs for posting sponsored positions on Indeed.com to ensure the highest visibility to accelerate recruitment.
Total: $ 450.00

IT Manager: The IT Manager will be responsible for overseeing first phase implementation, including serving as the Chairperson for the Implementation Team, monitoring all aspects of plan progress, care plan development and implementation, quality measures, reporting, and developing training materials. IT Manage will also work with consultants to develop configurable forms and specialized reports.
429 hours @$35.46
Total: $ 15,212.34

IT Consultants: The IT Consultants will analyze current paper process, develop electronic workflow, create electronic configurable forms
119 hours @ $50
Total: $ 5,950.00

Fringe: FICA, Unemployment, Workers Compensation, Pension and Health Insurance
Total: $ 7,522.70

Years 2-5 Budget-Operational Infrastructure Investments:

IT Manager
2019: Responsible for overseeing the second phase of implementation, including ensuring all aspects of record have been designed and tested in Carelogic, and developing training resources.
2019: 584 hours @ 36.53
Total: $21,333.52

2020: Responsible for continuing oversight of the second phase of implementation, including ensuring all aspects of mobile access are established and tested in Carelogic. This will improve ability to effectively work with families in community locations.
2020: 286 hours @$37.62
Total: $10,759.32

2021: Responsible for research and planning for FSA to use the MassHIway to securely share data and communicate with other providers. This includes ensuring the proper technology is utilized, updating security policies and developing and deploying employee training.
260 hours @ $38.75
Total: $10,075.00

2022: Responsible for completing connection and ensuring FSA can use the MassHIway to securely share data and communicate with other providers.
160 hours @ $39.92
Total: $6,385.60

IT Consultants: Analyze current paper process, develop electronic workflow, create electronic configurable forms, test and edit forms and complete final deployment.
100 hours @ $50
Total: $ 5000.00

CSA Supervisor: Continue role as EHR champion in support of implementation, workflow changes, staff training and troubleshooting with IT Manager and Consultants
44 hours @ $29.52
Total: $1,298.88

Human Resources: Recruitment costs for posting sponsored positions on Indeed.com to ensure the highest visibility to accelerate recruitment.
2020: $500.00
2021: $500.00
2022: $250
Total: $ 1,250.00

Fringe: FICA, Unemployment, Workers Compensation, Pension and Health Insurance for budget periods 2-5
Total: $ 16,334.68

Technology **Total:** $ 54,285.00

In the box below, please provide a description of all line items within the Technology investment category (e.g. Health Information Technology and care management software, IT project management resources, data analytics capabilities, ICC service delivery technology). Please specify the goals and project(s) this investment will support, as described in Section 3.4 and Section 6 of the RFR and explain how these investments will support the Contractor's performance of the Contract.

Prep Budget-Technology Advancement Investments:

The goal of this project is to create a fully functioning, comprehensive electronic health record that will provide consistent and timely reporting and support achievement of quality measures. The EHR will support secure communication with other providers and full functionality with the Mass HIway. Furthermore, the EHR will support integration of care, care planning and care coordination by being fully accessible to all registered users from any community location, putting the electronic health record at the worker's fingertips whenever and wherever it is needed.

Hardware Investments: Provide all ICC's with updated laptops. This will improve program's ability to be mobile allow real time to access EHR, improve documentation standards, and support compliance.
18 laptops @ $600.00
Total: $10,800.00

Qualifacts Consultant Project Manager: Responsible for designing EHR Implementation Plan and overseeing initial phase of project implementation
55 hours @ $150.00 per hour
Total: $8,250.00

Qualifacts Consultants: Responsible for creating specialized reports and complex configurable forms to support comprehensive data collection and seamless customization of EHR
30 hours @ $150.00
Total: $4,500.00

Year 1 Budget-Technology Advancement Investments:

The goal of this project is to create a fully functioning, comprehensive electronic health record that will provide consistent and timely reporting and support achievement of quality measures. The EHR will support secure communication with other providers and full functionality with the Mass HIway. Furthermore, the EHR will support integration of care, care planning and care coordination by being fully accessible to all registered users from any community location, putting the electronic health record at the worker's fingertips whenever and wherever it is needed.

Qualifacts Consultant Project Manager: Responsible for aiding in the deployment of the Implementation Plan and consult with IT Manager to troubleshoot implementation challenges
10 hours @ $150.00
Total: $1,875.00

Qualifacts Consultants: Continue report writing and creation of configurable forms as EHR Implementation unfolds.
36 hours @ $150.00
Total: $5,400.00

Remote Access: MiFy subscription to support mobile internet access
8 users @ $30 per month plus base account
Total: $2,880.00.

Years 2-5 Budget-Technology Advancement Investments:

The goal of this project is to create a fully functioning, comprehensive electronic health record that will provide consistent and timely reporting and support achievement of quality measures. The EHR will support secure communication with other providers and full functionality with the Mass HIway. Furthermore, the EHR will support integration of care, care planning and care coordination by being fully accessible to all registered users from any community location, putting the electronic health record at the worker's fingertips whenever and wherever it is needed.

Remote Access: MiFy subscription to support mobile internet access
8 users @ $30 per month plus base account
Total: $2,880.00

Qualifacts Consultants: (2020) Assist in reconfiguring service documents in the EHR to support interface with Carelogic Mobile Application. Once fully implemented, this App will eliminate the need for MiFys.
48 hours @ $150.00
Total: $7,200.00

Carelogic Mobile: Estimated fees for Carelogic Mobile Application in 2020, 2021 and 2022
3 years @ $3,500 annually
Total: $10,500.00

Family Service Association (FSA) has submitted a bid for other programs that may receive funding under the DSRIP program. Specifically, FSA has submitted a bid for the Long Term Services and Supports (LTSS) Community Partners program. FSA will ensure that projects supported with funding received under this Contract will not also be funded with other DSRIP related finding by virtue of the fact that these funds will be applied solely to the Community Service Agency. The FSA application for the Long Term Services and Supports applies only to elder service programs. Additionally, this bid addresses workforce development that is specific to Wraparound which is not used in the LTSS services. Finally, the Technology Advancement project targets customization of the EHR that is specific to CSA operations which has not applicability or relevance to FSA's LTSS programs.

6.4 E. Sustainability: The sustainability of infrastructure and capacity building investments beyond the funding period is contingent upon the rate of referral and engagement, and the capacity of staff to meet quota and performance expectations. Given that the CSA is well-established and already handles a significant volume of referrals, and recognizing that the CSA has a longstanding reputation for the delivery of high quality, effective Wraparound services; FSA is confident that the infrastructure and capacity building efforts can be sustained with ongoing program revenues.

A system of checks and balances exists within FSA to monitor program performance, outputs, outcomes and compliance with deliverables. That same system will be applied to these infrastructure and capacity building projects. A solid process exists within the organization for monitoring revenue through monthly Profit and Loss statements which are compared to program budgets. This ongoing monitoring, tracking and analysis involves the Chief Financial Officer, the Chief Program Officer and program Directors; and enables the leadership team to respond quickly with appropriate strategies to revenue or expenses that are not aligned with the projected budget.

The Technology Advancement project will rely heavily on the configurable features of the current EHR to further support the CSA, evolving to a complete electronic record which is fully sustainable. FSA will make significant investment of DSRIP funds to the programming of the EHR's customizable features to design data entry, documentation, tracking and reporting modules. While this is a substantial investment; once completed, it will be fully operational using only resources within FSA's existing Information Technology department to sustain the EHR's functioning. This makes good use of infrastructure and capacity building investments to produce deliverables for the program that have no incurred cost once in production. The investment will also support achievement of quality measures. As the electronic workflow is built, the required, compliant choice will be the default choice. For example, the date of the last physical and dental exam can be programmed as required fields in service documents. Workers will not be able to sign or submit these documents unless the date field is completed. An alert system can then be assigned to the date fields, providing automatic notice to staff when the next physical or dental exam should be scheduled and a warning alert to supervisors when the date exceeds a given threshold, such as one year. In this way, the Technology Advancement project also supports achievement of quality measures. Creating these types of safeguards within the electronic record are one-time costs that are fully sustainable beyond the funding period. Throughout the funding period, the allocation for EHR consultant time titrates down; allowing for any additional modules that may be needed. It also allows for any modifications that may be needed to facilitate communication with ACOs and primary care providers, to improve our capacity to share and access information.

FSA has a keen understanding of material costs and what it will take to keep the program operational. This understanding is built from having provided human services for so long. It also is built from having operationalized a number of new and highly effective programs including the Community Service Agency, Therapeutic Mentoring, In-Home Therapy and the Family Resource Center over the last five years. In terms of material investments, such as computers, monitors, telephones and the like, FSA has a budgeting format that dedicates a percentage of revenues each year to program needs to upgrade and/or replace material goods as needed. FSA has a strong approach to sustainability in its existing system for budget management.

The second part of the infrastructure and capacity building investment is the Workforce Development Plan that includes training, skill development, demonstrating proficiency and recognition of advanced practice for

those staff who achieve established education and performance metrics. FSA believes this project is also fully sustainable beyond the investment period. We historically have extremely good retention. We still have staff on board in the CSA that started with the program. Other staff have been with the organization even longer than the program, transitioning into the CSA from other programs. FSA will employ a train-the-trainer model for the education components. This will create a pool of staff with the knowledge and experience to help build the skills of new staff as they are hired to replace staff lost to attrition or if/when new positions are created. We also plan to invest funds in a regional, shared resource library which will provide training resources outside of the investment period. Additionally, each year, as part of the employee evaluation process, workers are afforded an opportunity to identify any training needs they may have. Training requests and recommendations are then included in budget planning for the next fiscal year. The capacity building investment in the first two years will support Wraparound certification. The investment in future years will include topics detailed in the project narrative and the suggestions or recommendations received from worker feedback. Finally, but probably most important in the sustainability of these investments is FSA's strong fiscal standing.

6.5 COORDINATION WITH ACOS, MCOS, AND PRIMARY CARE PROVIDERS

In fiscal year 2015, FSA began work with the Steward Medicaid Care Network (SMCN) on a pilot project related to an Executive Office of Health and Human Services Infrastructure and Capacity Building Grant. The first successful pilot explored shared governance and enhanced organizational integration. The second pilot, which ran concurrently with the first, tested data integration, clinical informatics, and population-based analytics. This work has progressed and FSA is currently working with SMCN on a clinical integration project that addresses avoidable emergency department (ED) use. A sub-project within this pilot is to trial advanced integration of care with two CSA enrolled families, looking to help define what future integration may look like and identify what steps will be needed to advance care coordination between the CSA and primary care providers within the SMCN. This final pilot is in the early stages but is already showing promise and has made great progress in opening communication between the CSA, FSA and SMCN. The announcement in early June that SMCN was one of 18 health care organizations across the state selected to participate in MassHealth's Accountable Care Organization (ACO) program confirmed that the efforts on the pilot projects were valuable investments in time and resources. These projects have laid the groundwork for future meaningful collaboration. The progress made with SMCN demonstrates FSA's ability to work with ACOs productively toward common goals. FSA can now apply lessons learned from these pilot projects to advance our work with SMCN and to guide future work with other ACOs and primary care providers. The skills and expertise of the CSA staff is widely recognized and staff already coordinate care for enrolled youth with areas hospitals, other CBHI providers, social service providers and state agencies. Extending that reach to further collaboration and coordination of care with other ACOs, MCOs and primary care providers is a natural progression of what the program already does and what FSA has already achieved with SMCN.

Essential to continuing the progress made thus far is effective communication. Capacity funding will be used to promote bidirectional communication through technology advancement. Initial work with the SMCN has helped to inform the direction FSA needs to head to extend our digital capacity. The Workforce Development, with an emphasis on Wraparound processes, including team building, will also help to promote the care coordination that will be required to achieve the state's DSRIP goals. Enhancing FSA's capacity for secure digital communication will ensure that interdisciplinary care plans can be shared with all members of the team serving the youth/family. Ensuring a secure platform for the digital exchange of data will also serve to further communication from providers to FSA. Representatives from ACOs and primary care providers will be invited to participate in Systems of Care meetings and multi-disciplinary team meetings to further promote coordination and collaboration. Extending our digital capacity to include virtual meeting attendance will allow family, community providers and other team members the opportunity to consult and participate in team meetings when actual attendance cannot be achieved. This time saving and cost effective measure extends the reach of providers and facilitates communication. Furthering the concept of telemedicine will also foster effective communication and open service delivery options for persons served.

The current CSA structure that utilizes an Intake Coordinator supports efficient referral management. To date, the CSA has never had a development plan related to timely access to services. This is due in part to the programs strong leadership, the establishment of reasonable caseload assignments, careful oversight of referral and intake activity and the development and deployment of the Intake Coordinator position. The Intake Coordinator works closely with the CSA Director and SCCs to triage and prioritize referrals and ensure appropriate case assignment. All referrals go directly to the Intake Coordinator, who gathers required information to complete the intake, conducts initial screenings for medical eligibility and community safety, and provides information to families on the CSA program and the intake process. The Intake

6.5 COORDINATION WITH ACOS, MCOS, AND PRIMARY CARE PROVIDERS

Coordinator serves as the point of contact for families during Intake. Centralizing intake with one full-time individual allows families in the referral stage, and referring providers, a single contact point to keep the intake/process moving forward. It also allows for the development of relationships between frequent referral sources and the CSA. As soon as a referral/intake is completed, the Intake Coordinator triages the referral and makes a tentative assignment considering staff availability, the urgency and complexity of the case, and the linguistic needs of the family. At least one member of the CSA Leadership Team (Director and SCCs) are on-site during program hours and readily available to consult with Intake Coordinator to confirm assignments when needed. Using this system makes the best use of resources, ensuring that referrals assigned to an ICC or FP are ready for immediate contact and intervention. This organized, efficient and effective process helps ensure there is consistent and timely access to services.

The well-structured staffing and supervision plan within the CSA supports performance beyond the intake and referral phase of engagement. CSA staff demonstrate fidelity to Wraparound processes; including team building. The program is currently working to build upon past success to further enhance team building skills. This includes team-based treatment planning and collaboration with pediatric providers. The CSA staff have strong connections with the pediatric providers in the Greater Fall River and they continually strive to maintain open communication. The CSA utilizes service delivery teams comprised of an ICC, and when clinically indicated, a FP. This care delivery team extends the capacity of the program to meet all of the needs of the youth served and his/her family. The Technology Advancement project proposed will extend existing capacity, deploying additional mobile devices and applications to foster communication with family, informal supports, other involved community members, behavioral health staff and primary care providers.

Linkage to appropriate community resources and social services is another strong component of the CSA. The FSA Family Resource Center is an excellent option for up-to-date resources and opportunities for families. Both the Resource Center and the CSA continually build reference libraries of available resources within the Greater Fall River area, and materials are continually updated. The technology advancement proposed for this funding will facilitate the use of digital resources in the homes of service recipients and during outreach work for rapid access to information. The Technology Advancement project proposed for capacity funding will put real-time information at the fingertips of ICCs and FPs. Rather than telling families they will research options and get back to them, they can research with families, in the moment when the information is needed. This can also serve as a teachable moment, demonstrating to families how they can seek information. While many families may not have access to the internet, it publically available through the Family Resource Center, various community entities, other service providers and public libraries, but families need to be taught how to use this valuable resource. As the FSA EHR evolves and becomes a singular integrated record, staff will have access to that record anywhere they serve families with the aid of technology deployed as part of this funding. This will further support timely follow-up, information sharing and collaboration with primary care providers. The Workforce Development strategies will contribute to building strong and effective care delivery teams comprised of multiple community providers. The strong Systems of Care Committee that currently exists will further promote timely access and connections to social services. The Interagency Team is yet another tool available to coordinate care, avoid duplication and promote favorable outcomes for CSA enrolled families.

FSA will also apply capacity building investments to improve our ability to use the MassHiWay in year's four and five of the investment. Physician practices were introduced to the MassHiWay as part of meaningful use. We will work towards accessing and implementing this platform as part of the Technology

advancement project to support integration of care and health promotion. Since physicians are already familiar with, and using this platform on a regular basis, aligning FSA with the MassHiWay will further support secure communication and promote coordination with ACOs, MCOs and Primary Care Providers.

CSA Budget Report

Gandara Mental Health Center, Inc.

Investment Funding		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites		1	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate		NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)		119	119	119	119	119	119	
Estimated Funds		$ 98,556.00	$ 83,300	$ 49,980	$ 35,700	$ 31,416	$ 14,280	**$ 313,232**
At- Risk Withhold Rate				5%	10%	15%	20%	
Withhold				$ 2,499	$ 3,570	$ 4,712	$ 2,856	**$ 13,637**
TOTAL MAXIMUM FUNDS AVAILABLE		$ 98,556.00	$ 83,300	$ 47,481	$ 32,130	$ 26,704	$ 11,424	**$ 299,594.60**
Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Project 1 Name: *[Create and Implement a Marketing, Education and Shared Communication Plan with ACO/PC Providers]*								
DSRIP Goal(s) Addressed:	Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery		$ 6,705	$ 6,000	$ -	$ -	$ -	$ -	**$ 12,705**
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development								
Workforce Development staffing including Fringe			$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses		$ 1,000	$ 1,000	$ -	$ -	$ -	$ -	**$ 2,000**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 1 Total		$ 7,705	$ 7,000	$ -	$ -	$ -	$ -	**$ 14,705**
Project 2 Name: *[Technology improvements that support cross-system communication and service outcomes.]*								
DSRIP Goal(s) Addressed:	Goal 1:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
	Goal 2:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ 23,676	$ 17,494	$ 16,780	$ 13,000	$ 9,000	$ 7,498	**$ 87,448**
Technology for Service Delivery		$ 16,320	$ -	$ -	$ -	$ 5,000	$ -	**$ 21,320**
Other Technology Expenses		$ -	$ 20,291	$ 17,770	$ 8,504	$ 3,960	$ 2,142	**$ 52,667**
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 2 Total		$ 39,996	$ 37,785	$ 34,550	$ 21,504	$ 17,960	$ 9,640	**$ 161,435**
Project 3 Name: *[Staff Capacity building]*								
DSRIP Goal(s) Addressed:	Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development								
Workforce Development staffing including Fringe		$ 4,600	$ 4,600	$ 4,600	$ 4,600	$ 4,600	$ 1,842	**$ 24,842**
Recruitment Expenses			$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses		$ 25,130	$ 5,000	$ 3,650	$ 4,350	$ 4,000	$ -	**$ 42,130**
Retention Expenses			$ -	$ -	$ -	$ -	$ -	**$ -**

Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 3 Total		$ 29,730	$ 9,600	$ 8,250	$ 8,950	$ 8,600	$ 1,842	**$ 66,972**
Project 4 Name: *[Development of Comprehensive Evaluation Process]*								
DSRIP Goal(s) Addressed:	Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
	Goal 2:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
	Goal 3:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ 21,125	$ 1,342	$ 2,636	$ 2,000	$ 2,000	$ 1,500	**$ 30,603**
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ 20,000	$ -	$ -	$ -	$ -	**$ 20,000**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 4 Total		$ 21,125	$ 21,342	$ 2,636	$ 2,000	$ 2,000	$ 1,500	**$ 50,603**
Total Project Costs		$ 98,556	$ 75,727	$ 45,436	$ 32,454	$ 28,560	$ 12,982	**$ 293,715**
Indirect Costs/ Administrative Overhead Rate	10%	$ -	$ 7,573	$ 4,544	$ 3,245	$ 2,856	$ 1,298	**$ 19,516**
Investment Projects Total		$ 98,556	$ 83,300	$ 49,980	$ 35,699	$ 31,416	$ 14,280	**$ 313,231**

CSA Budget Report - Budget Narrative Prep Budget Period

CSA_Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name: Create and Implement a Marketi

DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-Eng*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
PVIX	$ 6,705.00
Total Technology for Service Delivery	$ 6,705.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

The PVIX Health Information Exchange is a clinical portal that connects 16 of the largest Primary Care providers in the region with eachother. It allows for health information sharing and coordination. The costs are for our current EHR provider to engineer the connection to the PVIX system/ portal @$188/per labor hour to Remarkable Health to make the modifications. $6705 represents a small percentage of the total cost of impolementation, which will not be more than $20,0000. The exact cost quote is not expected from Remarkable Health until 12/18/17. Speifically, Remarkable Health will be: - Creating connectivity to PVIX Server via Mirth appliance, Managing and sending A03, A04, and A08 messages in response to system events, Testing and validation of the message form to PVIX's connection profile, Alterations to message assembly to conform to PVIX connection profile as needed, and Monitoring and general operational oversight of the message transfer.

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Technology improvements

DSRIP Project Goal(s):
1 *(3) Improving timely access to ICC services for children eligible to receive ICC an*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Ehana care management system	$ 23,676.00
Total Development and Adaptation of EHR and Care Management System	$ 23,676.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:
Expansion of current EMR System (Remarkable Health) with a new "front end" system (Ehana) to expand and enhance care management capabilities and EMR capabilities related to ICPs'. Costs are based on the development of the system and the implementation. This system will be utilized only for the CSA DSRIP Progam. It will be developed seprately from the BH CP's eHana platform, under seprate contract, with outcomes and timelines specific to the CSA. The estimated amount to develop the CSA eHana care management platform is $23,676. The eHana system will improve the delivery of ICC services by increase the capacity of the program to share and coordinate information with PCPs, streamline quality measure collection and tracking, and assist in the devlopment of QI paractices.

Technology for Service Delivery

Description of Expense	Cost
~~Mobile Offices~~	
5 Laptops ($1500 each)	$ 7,500.00
14 Printers ($280 each)	$ 3,920.00
14 Signature Pads ($350 each)	$ 4,900.00
Total Technology for Service Delivery	$ 16,320.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Purchase of Mobile offices which includes 5 laptops ($1,500 a piece), for 5 -FTE staff memberss(all staff have laptops, however some of them need to be upgraded to run the additional hardware), 14 mobile printers ($280 a piece) for 14 FTE staff , and 14 signature pads for 14 FTE staff ($350 a piece).

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name: Staff Capacity building

DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care planning*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name: Development of Comprehe

DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care planning*
2 *(3) Improving timely access to ICC services for children eligible to receive ICC an*
3 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
PERFORMANCE MGT CAPABILITIES: Develop the capability to track outcomes and deadlines electronically (Back-end reporting)	$ 21,125.00
Total Development and Adaptation of EHR and Care Management System	$ 21,125.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Remarkable Health EHR enhancements. Gandara utilizes Remarkable Heath (RT) Electronic Health Record, which is certified Meaningful Use Complete by Drummond Group and is deployed in two large community-based provider organizations within Massachusetts. **$21,125** is estimated to be utilized to make modifications and additions to Remarkable Health. which reflects the costs of Remarkable Health labor hours to create the Individual Care PLan, Safety PLan , and SNCD within the system, which are currently either tracked on paper or are currently insufficient to gather information needed for the quality measures.
Remarkable Health charges a flat $188 per hour for any additions and modifications to the system. At this point we have rough estimates from RH on how many hours each of the forms will take to get into the system.
The Individual Care Plan will be a minimum of 15 hours, the Safety Plan and SNDC forms are estimated at 10 hours each. We anticipate as we get further into the process additional modifications will need to be made to our existing forms in order to better track data and outcomes (for example we may need to change a field from a text box to a dropdown menu to better report certain information, these types of changes would have a cost associated)

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Workforce Development - Prep Budget Period

Project 1 Name: none

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Training Materials	$ 1,000.00
Total Training Expenses	$ 1,000.00

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Information materials developed to be provided to pediatritions to understand what the Gandara CSA services will contribute as part of the whole integrated care objective. Costs are comprised of printing and copying costs of the informational packets. It is estimated that the team will reach approximatley 139 PCPs in 28 service locations and 3 private practice PCPs for a total of 31 service locations and 142 unique PCPs. through a combination of individual outreach and outreach to practice managers who over see a number of PCPs.

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: none

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name: Staff Capacity Building

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Staff Recruiter	$ 40,000.00	0.1	12	$ 4,000
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0.1		$ 4,000
	Fringe rate	15.0%	Total Fringe	$ 600
			Total Workforce Development Staffing including Fringe	$ 4,600

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

To support the hire of a 0.1 FTE recruiter in Puerto Rico/Florida to support the goal of recruitment of qualified, representive, bi-lingual and bi-cultural staff which is important because GC's CSA is the only specialized Hispanic focused CSA in Massachusetts with a majority, minority client population.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
ARC for 30 CSA staff ($266.66 per staff)	$ 8,000.00
MI 3 day intensive for 2 CSA staff ($650 per staff)	$ 1,300.00
Vroon Training (30 staff at $221.67 per staff)	$ 6,650.00
Licensing Support for 4 staff at $2295 per staff)	$ 9,180.00
Total Training Expenses	$ 25,130.00

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Expands/enhances Care Coordinators overall knowledge, practices, communication skills and the ability to extract client information as well as the ability to provide trauma informed care for families and children. In terms of supervisorary support, licensing support will expand the capacity to handle more referrals eliminating the current waiting list.

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name: none

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 1 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate: 0%

Provide a brief description of how the Indirect Cost/Administrative Overhead rate was determined: We are not charging an Indirect Cost to the Prep Budget period.

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS March 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
1	Create and Implement a Marketing, Education and Shared Communication Plan with ACO/PC Providers	Implement the PVIX Health Information System	11/01/17	01/01/18	**Technology**	Technology for Service Delivery	The IT Director will complete the PVIX set-up by January 1, 2018	Demonstrated by documentation on the system						
1	Create and Implement a Marketing, Education and Shared Communication Plan with ACO/PC Providers	PCP provider that are connected to GC participants will be educated on goals, requirements, and communication practices of CSA integrated care.	12/01/17	03/30/18	**Workforce Development**	Training Expenses	1. CSA/CBHI Division Director is responsible for developing informational packets for PC providers by December 1, 2017 '2. COO and ED are responsible for the development of the MOU by December 1, 2017 '3. By MARCH 30, 2018, 100% of Ped providers who see GC CSA participants in Hampden county will be contacted	1. Completed informational packets 2. Completed MOU 3. Executed (signed) MOUs with PCPs who work with GC participants						
2	Technology improvements that support cross-system communication and service outcomes.	Implementation of eHana Care Management Platform	11/01/17	03/15/18	**Technology**	Development Adaptation of EHR and/or Care Management System	COO & ED are responsible for ensuring that the eHana sytem is ready for staff use by March 15, 2018	All appropriate staff will have access to they system and be trained to utilize it.						
2	Technology improvements that support cross-system communication and service outcomes.	Deployment of 'Mobile office" hardware	01/30/18	02/15/18	**Technology**	Technology for Service Delivery	1. COO is responsible for purchasing mobile office equipment and by Jan.30, 2018. 2. IT Associate is responsible for training staff on the functionality of mobile office hardware by Feb. 15, 2018	Staff will be utilizing mobile office suites and will increase efficiency as demonstrated by data being entered remotely.						
3	Staff Capacity building	Staff recruiter on-board to focus on Florida, Texas, amd Puerto Rico	12/01/17	01/15/18	**Workforce Development**	Recruitment Expenses	1. COO/HR is responsible for posting the job listing by Dec. 1, 2017. 2. COO/HR are responsible for completing the hire by Jan. 15, 2018	GC's recruiter will increase the number of qualified, bi-lingual candidates, who stay with GC for at least (2 years), to 10 per year over the next 4 years.						
3	Staff Capacity building	GC's ICC staff will participate in the **advanced level trainings provided including: ARC, MI, Tier 1 & 2**	01/01/18	07/31/18	**Workforce Development**	Training Expenses	By (January 2018), (20) providers will begin participation in the advanced level trainings provided including: ARC, MI, Tier 1 & 2	Registration completed for all trainings with participant lists						

Section 6.2 Executive Summary: **5- Year Development Plan and strategies for improvement:**

A. **Current performance on Development Plan:**
The Gandara SCSA development plan was updated in April/May, 2017. It addresses the five core goals as follows.
Reduction in Wait Times: The SCSA recruits qualified bi-lingual/cultural CC staff from Puerto Rico and has a well- established relationship with a university in PR. Retention data indicates that CC staff average turnover rate, over a 2-year period is 25% and FC turnover is 38%. QI processes indicate that form many staff, their skills and preferences do not lie in community based outreach and wraparound care coordination model. One new ICC team has been hired since April, 2017. New ones are hired as a team's caseload is nearly full.
Timely Completion Rates of CANS: The team has identified that reducing staff turnover and improving the tracking of CANS during transfers of cases to new ICC staff, and CANS completion monitoring during individual supervision improves this performance area.
Improving the TOMs' weakest principle–Natural Support Plans-specific 8. B.* The FS&T Director is creating a best practice list improve participation of natural supports that represents a balance of formal services and informal supports.
Improve score for WIFI weakest principle - B23.* The ICC Sr. Coordinator and QM Manager have developed and are administering a survey for families to help identify their areas of concern around transition prior to actual transition plans being developed.
Improve documentation in medical records and discharge from ICC services. The SCSA team identified five new concrete steps to improve chart audits, weekly reviews in supervision, and forms that will help to monitor and improve complete and timely documentation.

B. **Examples of strengths and needs;**
Gandara's organizational strength is based on its core mission to provide an array of prevention, behavioral health, residential and community support services, to adults, families, children, adolescents, and young adults, that are provided by staff who are majority bi-lingual/cultural at all levels of the organization. Nearly all participants face severe social and economic disparities, and are supported by staff who frequently have experienced similar challenges and disparities. Over the past 40 years, our capacity expanded to include minority populations other than Hispanic, including; Nepalese, Portuguese, and African American.

These skills have lead the organization to be responsive to the CBHI needs of many communities across the state with high concentrations of minorities. In the past two years, the SCSA has added to Nepalese care coordination teams for the Springfield region. This capacity for "relatability" results in high engagement scores for full CPT meeting attendance, effective teamwork, use of natural and community supports and strengths-driven services. Our WIFI data also demonstrates high rates of where the family and youth acquire a high understanding and capacity to manage/respond effectively to crises and utilize culturally receptive services and supports.

Similar to many other organizations, Gandara's CSA faces challenges with full participation of representatives from other systems within a youth's life (schools, child welfare/justice), and ensuring that team members follow through on priorities and action steps at the CPT meetings. The region has two SOC's meetings (one Hispanic focused and the other all community) which

has evolved to a bi-monthly combined SOC meeting with the individuals CSA's meeting the alternate month. Representatives across community systems *do* attend these meetings, but it does not translate down to CPT meeting attendance.

Gandara's CSA faces challenges with staff recruitment and retention, which creates a constant need for new and on-going training, from a culturally informed lens, and impacts several areas identified through the TOM's and WIFI evaluation. Needs themes include the capacity to fully implement the Wraparound model, that constantly reaffirms family/youth needs at each meeting, prioritizing and follow trough of action steps, addressing the needs of all family members, constant review of progress, and readiness for discharge. Based on these needs, DSRIP funds have been targeted for recruitment and retention, training, enhanced EHR and Case Management tools that will support self and supervisory review of records, required timelines, client progress, and better developed outcomes and evaluation monitoring and activities.

C. Plans for improving timely access to ICC services: Gandara's SCSA plan to improve timely access to ICC services includes strategies to ensure capacity to enroll referrals into ICC services within the required time frames. Current ICC wait time standards (as of 12/11) require that youth/families, upon consent for services, should not wait more than 10 days for an intake and should be offered an appointment within three working calendar days of a referral to services. Strategies will include: ***hiring a dedicated HR staff person*** to recruit bi-lingual/cultural Hispanic clinical staff from Puerto Rico for positions in the agency which require bi-lingual capacity. (Gandara is also targeting Florida and Texas as recruitment sites due to the recent migration from PR). Only a portion of the cost of the position (approximately 10%) will be assigned to the DSRIP budget. Our target goal is to hire 30 bi-lingual clinicians through this new position. Additionally, the SCSA & Senior Leadership team are ***modifying staff recruitment practices to better access a candidate's viability for successful re-location.*** These practices will include retooling the interview questionnaire test alignment/capacity to work in a community outreach vs. an outpatient clinic site, understanding and capacity to apply an integrated care/wraparound practice, and provide more transition supports (e.g. 1st month's rent, relocation stipend, and assigning an experienced staff to work as a mentor with the new staff person). The SCSA has developed ***an enhanced training and supervision practice*** designed to improve timely completion of required SCSA practices and times-lines and addressed the unique on-going training needs comprehensive weekly group supervision and topical training schedule for the entire year. This also includes a new standard agenda and template for ICC supervisors, and new Intake Coordinators review case-loads, wait list and triage clients with supervisors. This is being achieved through existing resources. New certificate focused training (Project 3) funded through DSRIP, described below in section C and in section 6.4 a, will support staff retention and maintaining the level of care coordination teams sufficient to meet referrals.

D. Plans to improve ICC members engaged in care coordination, planning, management: Staff and administrators from ICC and FP department meet weekly to provide updates, conduct trainings and problem solve. A comprehensive 2017 training schedule includes trainings on our process and its implementation with clients, specific to cultural competency and the mandatory trainings provided to us by the Managed Care Entities(MCEs). Trainings include pre/post-tests to evaluate staff understanding of the subject area. Competency evaluations, developed by the agency QI/QA Director and ICC Supervisors, will be used to improve trainings, determine

individual staff who may need additional individual support/ training and provide measurable data to determine the overall strengths and weaknesses of our departments, and adapt practices to meet the cultural needs of participants. This is provided through existing internal resources (ICC & FP supervisors). New tracking tools and policies and practices are in the process of being developed and integrated into our Remarkable Health (RH) EHR ScoreTrak to aggregate and evaluate data.

New agency-wide training in the Attachment, Regulation & Competency (*ARC*) framework, is scheduled in 2018 for Gandara clinical staff, including CC supervisors and CC's. Also planned is all-staff training to apply culturally based *Motivational Interviewing* by job type and role of each staff. This interactive approach will improve the ICC team to better engage participants in accurate family information sharing and will help supervisors engage staff in performance improvement. Twenty (20) staff will participate in these trainings; Two supervisory staff will attend and obtain certificates for Vroon Vandenberg Tier 1 and Tier 2 (Integrated PC/BH Wraparound practices) certification. Trainings will be completed by 7/1/18.

E. Plans to improve performance on quality scores and Development Plan goals: Plans to improve both the quality scores and Development Plan goals include: New technology, funded through DSRIP (Project 2) will purchase "mobile office" products (laptops, mobile printers, and signature pads) and associated training that will support care planning, management and coordination for ICC engaged members/families (by January 30, 2018). A Care Coordination/ Care Management software platform (eHANA) will be created by April 1, 2018, to support PC/MH integration and support a QI process. (Staff capacity building (Project 3), will include adding on-line assessment tools into our EHR that will enhance monitoring and capacity to aggregate and review staff/program performance through chart audits and new QI processes including formal monthly reviews of data to monitor quality, and compliance with benchmarks; the new staff training practices described above. (by April 1, 2018). The Division/Project Director (C. Ezzo) along with the IT (DiVito, EHR (Dones), and QI Director (Murphy).

F. Plans for improving coordination with pediatric primary care and other physical and behavioral health care providers across the care continuum for youth. The SCSA will implement a three-tiered process to improve coordination with PPC and other physical/BH providers. General presentations are being prepared for key PPC practices that serve a large number of our engaged enrollees. These will be followed up with an information packet and draft MOU to outline information sharing, notifications/communication practices and CMT input/ participation. When possible, specific teams will be assigned to a PPC practice to promote coordination. SCSA staff will participate in a half day training on culturally focused PC/BH Integration, and the inclusion of Wellness goals in each care plan. The SCSA has well established relationships with other physical and BH care providers across the care continuum that is supported through integrated System of Care meetings (with both local CSA's) that help to identify barriers and solutions to care. Enhanced supervisory and file review practices will support the monitoring care plans, promote accountability and identify areas in which there are coordination lapses.

Section 6.3 Populations Served and Community Engagement
Description of populations and communities served, plans to promote health and wellbeing, and plans for engagement;
GC was established to provide outpatient mental health and substance abuse treatment to Springfield's large, underserved Hispanic community. It has been a licensed outpatient clinic since 1977. As a State Office of Minority Business Assistance (SOMBA)-certified minority agency, GC's mission is to promote the well-being of Hispanic, African-American, and other culturally diverse populations through innovative, culturally competent health, prevention, education and treatment services. Our goals are two-fold: 1) to address disparities in access to quality BH treatment among Hispanics and other minorities through culturally nuanced services provided by highly trained staff who respect participants' beliefs, attitudes and service choices. 2) create a culture of recovery and well-being that focuses on building and sustaining participants' physical, mental and spiritual health, their engagement in supportive relationships, and promotes productive participation in the community.

GC served 13,492 clients through four service divisions in FY16, including Clinical Services, Adolescent & Family Services (AFS), Residential & Community Services, and Prevention & Community Outreach. Among the combined programs, 58% were male, 41% female and 1% transgender. 69% were Hispanic (including 40% Puerto Rican). In terms of race, 49% White; 21% Black; 23% Other; & 7% Bi-Racial. 17% expressed a language preference other than English. Age characteristics: 9% aged 6 or less, 18% aged 7-13, 14% aged 14-17, 17% aged 18-30, 25% aged 31- 50, 16% aged 51-70, and 1% aged 70+.

GC is the only Hispanic focused SCSA in the state, with Western regional sites in Springfield and Holyoke. Springfield and Holyoke are both majority, minority communities with high rates of emigration from Puerto Rico. Within the Hispanic population these communities have some of the highest rates of health disparities and primary and behavioral health capacity gaps. In FY16, 92% of the families served represented minority populations with 75% Hispanic, 9% Nepali, 8% African-American and 8% Caucasian. 60% of the youth are male and 40% female. 25% of the youth are age 0-6; 50% are 7-13; 20% are 14-17; and 5% are 18-20.

Plans to promote health & wellbeing are informed by the individuals served and tailored to youth and family needs. ***Existing activities include***: *An annual nutrition group – the last time the group was offered 6 families attended *Bi-annual family voice forum—engaged families are invited to a facilitated forum to express their ideas, concerns, and successes. *The ICP process and planning frequently includes recreation activities based on youth interest, strengths and needs. Any wellness related activity is tied to the overall care plan. ***New strategy:*** The program will develop a strategy to carefully monitor CANS assessments and scores with an eye for health and wellness needs. Both the caregiver and youth sections include wellness related measures i.e. family stress and around life domains. ICC supervisors, through increased monitoring and training will ensure that scores of 3-4 in any of the health & wellness area is included in the ICP.

Plans for engagement are predicated on the knowledge that engagement is an on-going process and best achieved through a strength-based, trauma-informed approach. The program employs the following strategies with enrolled families: *Visual/family friendly tools to explain program

services; *ICC staff work with a family to address immediate needs first. For example, if staff notice during the initial meeting the family doesn't have enough food they will complete the minimum required paperwork (consent/releases/safety plan). Then work with them to secure food that day. This strategy builds trust and demonstrates staff to be responsive to family needs, increasing the likelihood of ongoing engagement. *Flexible meeting times and places—families can meet with ICC staff wherever they are comfortable, at a time that works for them. *Staff educate families on the principles of Wraparound including persistence, voice and choice and model behaviors that empower families and give them control over the process, further supporting engagement. *Staff utilize Motivational Interviewing to better understand the family's motivation for seeking services and work from that foundational understanding. *Celebrate accomplishments – CCs call other members of the care team to share family successes; accomplishments are always the first item discussed at care team meetings, and CCs plan frequent gatherings to celebrate milestones like graduation, and transitions.

B. Description of community relationships:

GC-SCSA services are embedded in the community since 2009, and has well- established relationships with providers across a broad domain of services, that include service level relationships. New staff are trained in all SCSA linkages and introduced to all community partner staff. The chart below outlines key partners in each service area.

Care/services	Name of organization	Description of Relationship
Family Organizations	Gandara's Family Resource Center	Evidence based parenting classes, group support, and family engagement/ community/ recreational events; educational liaison and other family support
	Spg. Parent & Community Engagement Center	Attend events hosted by the center, refer families, communicate regarding parent/children's needs
Schools	Holyoke Community College	Developing a sustainable Workforce Development program for staff and community member
	All elementary and High Schools including alternative, & charter schools in Springfield & Holyoke.	Engaged as part of care planning team
Childcare Providers	New England Farm Workers	Child care resource and referral/voucher child care program, serves families in Hampden, Berkshire, Hampshire and Franklin counties.
Community Based Organizations	Enlace de Familias	Parenting programming and resources to families; food, housing, and public school system referrals.
Youth Service Organizations	YMCA of Greater Springfield	Physical Health and Fitness (all ages); water safety and babysitting; Pre-school, Daycare and afterschool care offered, Diabetes/diabetes prevention programs
	MLK, Jr Family Services	Family support, shelter/housing, child/family services
Advocacy Groups	Federation for Children with Special Needs	Provides information, support, and assistance to parents of children with disabilities, their professional partners, and their communities.
	Parent/Professional Advocacy League (P/PAL)	family-run organization, with multicultural staff, helps families understand/navigate services.
Behavioral Health Providers	Holyoke Medical Center	agreement to provide recovery coaching services in the emergency room, integrate HMC primary care service providers into outpatient mental health clinic.

	Behavioral Health Network (BHN),	Cross-referrals; crisis/brief intervention & extended services as part of a follow-up and aftercare plan;
Child serving state agencies	DCF Springfield & Holyoke	Collaborate on a staff and administrative level. Working together on the Caring Together Grant
Trial courts	CHD- DYS Juvenile Justice Programs	Information sharing/cross-referrals, collaboration on shared participants
	SPRINGFIELD DISTRICT COURT	Coordinate and collaborate on referrals; regular communication on shared participants
Housing/ Shelter Programs	HAP Housing	Referrals for housing services including: RAFT, emergency housing, rapid re-housing, transitional housing, and landlord/tenant support and advocacy.
	Springfield Housing Authority	Referrals for housing services
	Friends of the Homeless	Emergency shelter, case management & support
Social Serv.	New North Citizens	Referrals, outreach assistance with detox
	Puerto Rican Cultural Center	increase education and cultural arts opportunities to the Puerto Rican/Spanish-speaking communities
	Main St Open Pantry	Provides an emergency food pantry, daily prepared meals, clothing, household goods.
Other:	Baystate Brightwood Health Center,	Provide cooperative service delivery in communities serviced by both parties.

C. Description of how the current & planned partnerships align with the proposed project.

GC has demonstrated capacity to integrate Behavioral Health services and Primary Care. GC has an established partnership with Holyoke Medical Center and its affiliated Western MA Physicians Association, to provide on-site primary and behavioral health services at GC's Outpatient Clinic, through a SAMHSA grant, including on-site medical and lab services, and a health and wellness program. Additionally, GC and Baystate's Brightwood CHC has a long-standing partnership where by a GC BH clinician is embedded in the health center 3 days/week. The clinician is part of the care management team and attends care coordination meetings. Additionally, clinicians are embedded in two Springfield and one Holyoke school.

These existing relationships will be leveraged to strengthen care coordination, and support ***integration*** with ICC and FS&T services. As outlined in Section 6.4.A, a key task during the implementation phase will be to meet with and establish referral, communication and collaboration practices with nine ACO's and over 15 different Primary Care partners to: cross-educate on services provided; build a shared understanding of the needs and capabilities of each partner i.e. what shared information would be beneficial to each, identify the communication channels; determine what resources will be needed; and develop formal care coordination protocols. GC has established formal relationships with many agencies/organizations/ providers including, but not limited to, those outlined. The principles of collaboration, cultural competence, strengths based, outcome based care coordination and planning, are actualized through the team process with members working cooperatively and sharing responsibility for a single care plan. A significant component of the proposed project is enhanced training to staff around effective coordination of care teams (see Sec. 6.4.A Project 2. pg 8-9). Technology improvements (Mobile offices, changes in the EHR, and the eHana care management platform) will create efficiencies around communication with other members of the youth/family care team. GC's existing bi-monthly SCSA Systems of Care meetings, and bi-monthly joint GC/BHN's Systems of Care meetings, further support fidelity to the Wraparound process by

creating "community teams", with shared goals, and effective referral mechanisms, along with new QI review practices.

Section 6.4 Proposed Project and Investment Plan

A. **Project description:** The Gandara SCSA has identified four projects in which DSRIP funds will be invested, as follows:

1. 1.***Project 1*:** Create and Implement a Marketing, Education and Shared Communication Plan with ACO/PC Providers.

***1. 2. DSRIP Goals Addressed*:** Foster Integration with ACO's and PC Providers for ICC-Engaged Members/Families.

***1. 3. Project Scope and Activities*:** By **MARCH 30, 2018,** 100% of the pediatric providers who see GC CSA participants in Hampden county will be contacted and educated on goals, requirements, and communication practices of CSA integrated care. To support this goal, by March 30th, 2018, GC's IT staff will test readiness of the PVIX Health Information Exchange system integration which allows for electronic communication with participating pediatric practices/FQHC's. By May 30th, CSA staff will be utilizing the PVIX system to monitor, and track PC visits, and care plans, and communication.

Duration of time funds will support this project: This project is planned to take place between November 15, 2017 and March 30, 2018.

Specific activities to achieve the goal are as follows: CSA staff, under the director of the Director of CSA/CBHI Services, will meet to design the information packet, and outreach materials, to be utilized during introductory meetings with ACOs, Pediatric Providers, and/or Practice Mangers (as appropriate) Packets will include: communication protocols, overview of CSA, referral flow chart. *Completed by December 1, 2017*.

Within the same timeframe, the project team will finalize and prioritize PCP/ACO contacts to be c*ompleted by November 30, 2017.*

GC's Executive Director and COO will develop an MOU to be used as a template for working with PCPs. This MOU will facilitate in the development and identification of shared priorities with GC and Pediatric Providers. The MOU will be c*ompleted by December 1, 2017.*

Upon completion of the previously described activities the project will begin a Relationship Building Phase with the identified Pediatric Providers and/or the ACOs. A list of all pediatric providers currently used by SCSA enrollees has been developed and visits will be prioritized based on the quantity of members who utilize a practice. The Gandara Executive Director and CSA/CBHI Division Director will schedule meetings with ACOs and/or Practice Managers as appropriate to develop a shared understanding of what we do, identify priorities and what they are required to do (in relation to integrated services), and a timeline to be driven by the MOU. *Meetings will begin December 1, 2017, and are expected to be completed by March 30, 2018.*

Next steps will be determined by the results of the "higher-level" meetings with ACOs. It is anticipated that contacts within the ACO will facilitate the connection/ relationship at the practice level. With this understanding, it is expected that practice level meetings will be *completed by Jan. 30, 2018, w*ith Practice Manager/Care Coordination level meetings *initiated by March 1, 2018*

Upon completion of a fully executed MOU, the Division/Project Director (Chris Ezzo) will develop staff training on the established communication protocols, deliverables (or desired outcomes/focus of efforts i.e. reduced ER visits), methods of communication, and tools identified to be used for cross-communication.

Additionally, as part of this project, IT staff will complete the PVIX Health Information Exchange system set-up, by following up with our RH EHR on interface integration. PVIX is designed to monitor, and track PC visits, and care plans, and communication, further supporting the goal of Integration. It is estimated that this system will be completed by January 1, 2018

1.4. Project 1 deliverables include a completed MOU for use with Primary Pediatric Providers (described above), a complete informational packet to facilitate introduction on the GC CSA program to ACOs, Practice Managers and/or Pediatric Providers, the completing of the PVIX system integration, and the development and completion of a meeting schedule. All deadlines for the delivery of these items are outlined above.

1.5. Specific Use of Funding: It is anticipated that $7,705 will be used to support the execution of this projects goals. Costs associated with the PVIX system are $6,705 and include a portion of the IT Director's time, $1,000 will be spent on printing and materials costs for the informational packets to be utilized to educated Primary Care Pediatricians on the programs goals and objectives.

1. 6. Existing Internal Resources will be utilized to support the Project will include the agency's EHR/Remarkable Health; IT staff time and expertise, SCSA and Senior Leadership time associated with the development of outreach materials, outreach visits, and MOU's.
Partnerships/Collaborations: Several key partnerships support the growth of care coordination and collaboration building and serve as a foundation for expanding connections with PCP's and BH providers.

- At the inception of the CSA in 2009, Gandara established a Hispanic focused System of Care meeting for Springfield/Holyoke, a monthly meeting which representatives of key systems (state agencies, BH crisis services, schools, emergency responders (police) and community based agencies). The meetings provide a key forum for education on the Wraparound Approach, Care Coordination, Family Partners, the ICP meetings and other CBHI resources, and the development of protocols that supported cross-agency safety plan responses. About a year ago, the organizations asked if the Gandara and BHN SOC meetings could occur jointly. Subsequently, the joint meeting occurs bi-monthly and on the alternate months the two CSA's have their own SOC meeting. Approximately, 20-25 organizations are represented at the SOC meetings.

- Gandara is one of 5 agencies that was approved to join the Western MA Pediatric ACO (PACO) which has nine practices will select which BH partners they want to work with. Gandara is the only Hispanic focused CBHI/SCSA service provider among the five.
- Gandara Center is part of a ACO-Community Partner application for Western MA submitted under an LCC Innovative Care Partners which includes the Center for Human Development, ServiceNet and Gandara Center. This will provide a platform and structure that will be mirrored in many aspects with our PCP relationships.
- Gandara Center has an established partnership with Holyoke Medical Center and its affiliated Western MA Physicians Association, to provide on-site primary and behavioral health services at Gandara's Springfield outpatient clinic (Main Street). The project is funded through a SAMHSA grant and in addition to on-site medical and lab services, it also provides a health and wellness program to participants.
- Gandara Center and Baystate's Brightwood Community Health Center has a long-standing partnership where by a Gandara BH clinician is embedded in the health center three days/week. The clinician is part of the integrated P/PH care management team and attends weekly care coordination meetings at the health center. This serves as a model for other potential collaboration with pediatric care practices partnerships that will be explored as part of the PACO partnerships.

Allocation: Resources will be allocated to Gandara's single Springfield/Holyoke based SCSA and applies to all project descriptions as outlined on **page 15** at the end of the descriptions.

Gandara's SCSA/DSRIP specific Evaluation Process applies to all projects outlined is this section and may be found on **page 16** at the end of the project descriptions.

1.7. Evaluation: The performance measure for this project will be to increase the number of referrals to ICC services. The goal will be to increase referrals from partner PCPs (those with which we have a signed MOU) by 5% by BP 2. Referral information is collected and tracked in Remarkable Health. Staff evaluating the performance will include: Chris Ezzo, Division Director, Freddy DeJesus, Executive/QA Manager; Heather Murphy, Agency Quality Manager. A referral report will be pulled by Heather Murphy and analyzed monthly by the project evaluation team.

Project 2

***2.1 Project Title*:** Technology improvements that support cross-system communication and service outcomes.

***2.2 DSRIP Goals Addressed*:** Strengthen fidelity to Wraparound processes (care planning, management and coordination for ICC Engaged Members/Families

***2.3 Project Scope and Activities*:** In an effort to build program capacity around communication with PCPs and enhance ICC staff ability to monitor service outcomes, by (November 30, 2017), the project team will initiate a process whereby a Care Coordination/ Care Management Software Platform (eHANA) will be created. This system supports communication across

stakeholders (i.e. EOHHS, ACO, MCO, PCP), including support for the exchange of documentation, alerts, reminders and prompts for the Care Team actions. By (April 1, 2018), the eHANA platform will be functional and (20) ICC staff will increase their ability to monitor key aspects of CC/CM including frequency of youth engagement with PCP, BH and other ICP supports.

Gandara's EHR & QI Directors will identify and develop a training curriculum for all new areas of technology tools. And ensure that by (April 1, 2018), (20) ICC staff will be utilizing new tools and increase timely service delivery and data entry efficiency and timeliness.

Additionally, hardware that will facilitate the creation of "mobile offices" will be in place to increase timely service delivery and data entry efficiency and timeliness. By (Jan. 30, 2018), (COO) will order components of mobile office suite to be utilized by ICC staff in the field. By (Feb. 29, 2018), (10) of ICC staff will be fully utilizing mobile offices.

Duration of time funds will support this project: November 1, 2017 – April 1, 2018

Specific activities to achieve the goals of this project include: the completion and execution of a contract with eHana to expand/enhance CM capabilities. It is expected that this will be completed by April 1, 2018. Modifications and development to GC's current EHR system and to eHana are required to ensure that both systems work together and provide GC with the intended results. These modifications will be completed by the respective system company. GC's COO and Executive Director are responsible for ensuring that the Overlay/coupling of the systems is completed by March 15, 2018.

The purchase and set-up of the hardware required for the mobile office suites including; new laptops, mobile scanners, and a signature pad will be completed by Jan.30, 2018. The COO will monitor completion.

To support the successful implementation of these new tools, the QI and EHR Directors will work together to design a training curriculum on all new technology tools. This training curriculum will be completed and deployed by April 1, 2018. The Division/project manager will monitor completion.

Additionally, it will be essential that the new systems are being utilized effectively. To that end, the Director of QI will develop a QI process to evaluate the accuracy and completeness of information being collected through the use of new tools (mobile office, PVIX, eHana). This will include the design and execution of a monthly report that will facilitate the monitoring of data entry through new systems. This will be monitored and reviewed by the Project Director, and the review team will include the S-CSA Director, ICC & FP supervisors, and the QI/QA director.

2.4 Project 2 deliverables will include: a contract with eHana for the Care coordination platform, and the completion of that system development; the completed purchase and deployment of mobile offices; the completion of a training plan and curriculum for the new tools; and the development of a QI process to ensure the effective use of the tools. All deadlines for the delivery of these items are outlined above.

2.5 Specific Use of Funding includes: **$16, 320** for mobile offices comprised of 5 laptops ($1,500 each), 14 mobile printers ($280 each), and 14 signature pads ($350 each). **$23,631** for the development and use of the eHana platform.

2.6 Existing Internal Resources will be utilized to support the project including existing staff time and expertise in the set-up and training on the new platforms, as well as the on-going monitoring activities associated with effectively deploying and utilizing the new systems, including the COO, SCSA Division Director, ICC supervisors, and EHR and QI/QA director.

2.7 **. Evaluation**: Fidelity Measures used will include increasing the CANS entry rate by 15% (83%) by BP-1; and 30% (98%) by BP2. Additionally, the team will review CC contact with PCP with the goal of achieving 95% communication rate between CC and PCP practice regarding ICP meetings, and updates on critical events that occur for families within 3 days of event. (BP-1). Data will be collected through reports available through both the Remarkable Health system and eHana. Reports will be pulled weekly for CANS entry and monthly for PCP communication.
Staff involved in the evaluation will include CC team supervisors, Freddy DeJesus (Ex./QA Manager and Chris Ezzo, Division Director, Heather Murphy, agency QA director will meet with the team monthly during the Prep Budget period and 1st half of BP1 and quarterly thereafter. BP1-5).

Project 3

***3.1 Project Title*:** Staff Capacity building (recruitment, retention, training)

***3.2 DSRIP Goals Addressed*:** Strengthen fidelity to Wraparound processes (care planning, management and coordination for ICC Engaged Members/Families

***3.3 Project Scope and Activities*:** To achieve the goal of this project GC will focus efforts on staff capacity building including enhanced training and recruitment activities. ***Training*:** By (July 31, 2018), (20) providers will increase their knowledge and fidelity to (Wraparound, MI, Care Coordination) concepts as demonstrated by completion certificates and/or post-tests, designed to test concept mastery by participating in the following advanced level trainings: ARC, Motivational Interviewing, and Vroon Vandenberg TIER 1 and Tier 2 trainings**.** *Recruitment:* GC's recruiter will increase the number of qualified, bi-lingual candidates, who stay with GC for at least (2 years), to 10 per year over the next 4 years. *Licensing Support:* Gandara typically may hire masters level clinicians who have not completed their licensing requirements which inhibits their capacity to supervise CC teams, and it is sometimes more challenging to achieve this due to language/adjustment challenges. The agency will allocate funds and support to pay for testing fees, workbooks, preparation supervision and the cost of paying for a clinical supervisor to meet licensing requirements. Four clinicians will be identified and supported for this support. The timeline to achieve this will be on-going, based on clinician readiness level, and the testing schedules.

Duration of time funds will support this project: December 1, 2017- July 31, 2018

Specific activities to achieve the goals of this project include; By (January 2018), (20) providers will begin participation in the advanced level trainings provided including: ARC, MI, Tier 1 & 2. The CSA/CBHI Division is responsible for documenting (certificates and/or test results) the completion of the Tier 1 training by May 31, 2018; Tier 2 by July 31, 2018; ARC by (TBD) and MI by (TBD). The CSA/CBHI Division Director will identify 4 staff members who are appropriate for Licensing support and document their passing of the test by May 31, 2018. The CSA/CBHI Division Director will identify a consultant, product and timeline for the coaching program by June 1, 2018.

Gandara's HR department will develop the job description and posting for the recruiter by Dec. 1, 2017. HR, in coordination with the project team, will screen and hire a staff recruiter, completing the hire by Jan. 15, 2018

3.4 Project 3 deliverables include the completion of all advanced level trainings as demonstrated by completion certificates and/or post-tests; completed contract with consultant to reinforce training topics; 4 newly licensed staff supervisors; and a fully on-boarded staff recruiter. All deadlines for the delivery of these items are outlined above.

3.5 Specific Use of Funding includes ARC training for 50 staff at **$8,000** (E), 3-day intensive Motivational Interviewing for 2 staff at **$1300 (E);** Vroon (TIER 1 & 2) at **$6,650 (E);** costs associated with licensing fees and supervision at **$9,**180 for 4 staff; and **$4,602** for approximately .10 FTE Recruiter.

3.6 Existing Internal Resources will be utilized to support the project include Retention bonuses— including a $500 referral incentive, $1500 at start date for non-licensed clinicians, $500 retention incentive at 6 months, $1000 for bilingual capacity and $1000 licensed clinicians. As well as the existing training opportunities and structure. GC's SCSA has received funding through the Technical Assistance Collaborative for the past year. This funding has been renewed and increased for FY18, and will be utilized to subcontract with Dr. Anne Thalheimer, who has designed and led multiple team building, writing workshops and cultural competency working with LGBTQ youth and families, for Gandara Center staff as part of their weekly meetings. TAC assistance, along with Sheree Greenwood and Omar Irizarry, helped core team leaders conceptualize, design, and hold a team retreat and training that was held for all staff members to reinforce Gandara's work and develop skills needed by CCs and FPs.
The scope of the training offered under this funding is as follows: In order to provide training for care coordinators, and in-home providers with a broader skill set for interviewing families with an eye toward more effective and comprehensive documentation for CANS, comp assessments, and other required documentation that requires minimal supervisor-initiated review. The consultant and CSA leadership staff will work in in concert to develop and hold a series of workshops and create training materials.

Additionally, Gandara has initiated and piloted a **Family Partner/Community Health Worker** training initiative through funding from the Commonwealth Corporation and in collaboration with Springfield Technical Community College and CBH Workforce Collaborative a network of 14 minority focused BH providers with the goal of strengthen culturally responsive patient care

for bilingual and racially diverse families. In Western MA, this initiative has been embedded as a 9-hour credit course sequence for a behavioral health focused Community Health Work certificate. Course material will include working with Pediatric ACO's, basic medical terminology, effective communication skills, and introduction to EHR requirements. This will offer a platform for the ICC team that will support the Capacity Building initiative.

3.7 Evaluation: Specific Measures to evaluate the impact of the activities will include: Current turnover rates of CC's is 25% within 2 years; the goal is to reduce this rate to 15% by BP 2; and for Family partners from 38% to 25% by the end of BP-1.The specific measure for Recruitment will be to increase access to ICC services and reduce waitlist times. The goal will be to be in compliance with current ICC wait time standards (as of12/11) that require that youth/families, upon consent for services, should not wait more than 10 days for an intake and should be offered an appointment within three working calendar days of a referral to services. Data will be collected on-going and tracked through Remarkable Health. The evaluation team: CC supervisors, Executive Mgr., Div. Director and HR Director will monitor on a quarterly basis the recruitment and retention rates, and the waitlist times and status on a weekly basis.

Project 4

4.1 Project Title: Development of Comprehensive Evaluation Process
4.2 DSRIP Goals Addressed: Strengthen fidelity to Wraparound processes (care planning, management and coordination for ICC Engaged Members/Families; Foster Integration with ACO's and PC Providers for ICC-Engaged Members/Families; and Improving timely access to ICC services for children eligible to receive ICC and their families.

***4.3 Project Scope and Activities*:**
Gandara plans to implement functionality within its Electronic Health Record to manage and track services delivered, referred, and coordinated within its SCSA and associated programs. Implementation projects include project management, training, and support. Gandara has already deployed its EHR technology (via vendor Remarkable) in all its sites and has a strong record of success with technology adoption in similar programs. Gandara's EHR vendor, will modify our EHR platform to include the SCSA ICP and the SNCD tools so that data from these documents can be aggregated through the ScoreTrak or by our data analyst through the back end and supplement our data tracking system, sufficient to track the new Outcome Quality Measures for the DISRP or in some cases replace elements of its existing data-tracking system. Screenings, assessments, plans, and service documentation will be reviewed and potentially updated based on best-practices and fidelity to a strengths-based model.

Duration of time funds will support this project: November 2017 – May 2018

Specific activities to achieve the goals of this project include; By (November 15, 2017), (EHR, QI & CSA/CBHI Division Directors) will begin development of enhanced back-end reporting in our existing EHR including a plan to transfer key EHR data into a SQL server, to allow for more advanced reporting by Data Analyst. The EHR, QI & CSA/CBHI Directors will meet to identify key areas of need in current system and plan for modifications and additions. EHR & QI Directors are responsible for coordinating and completing all modifications to the current EHR system and by March 1, 2018. Training: By (April 30, 2018), (EHR & QI Directors) will develop

a training plan and schedule on all new data collection, CM, and CC tools including the: ICP, SNCD, Safety Plan, and eHANA platform. EHR & QI Directors are responsible for completing staff training by April 30, 2018. By (May 1, 2018), the project team and GC's Quality Improvement department will develop a comprehensive Evaluation Plan to encompass the following areas: progress and effectiveness of each DSRIP project, increases program effectiveness in each of the required Quality Measures, and case management/care coordination effectiveness/fidelity. The goal of this plan will be to ensure that data that is key to monitoring and improving care coordination, case management, and timely access to services will be available to supervisors on a (MONTHLY) basis. By (June 1, 2018), monitoring and evaluation practices will be in place. By (October 15, 2018), the first quarterly comprehensive report will be produced covering the period of July 1- September 30, 2018.

4.4 Project 4 deliverables include: the completion of the Remarkable Health modifications as demonstrated by the additional forms on the system, a completed Evaluation Plan, and a comprehensive, monthly data report that includes all elements of the Evaluation plan.

4.5 Specific Use of Funding includes Gandara utilizes Remarkable Heath (RT) Electronic Health Record, which is certified Meaningful Use Complete by Drummond Group and is deployed in two large community-based provider organizations within Massachusetts. The EHR includes features and functionality intended to support integrated and collaborative models of care, including: Patient Portal functionality; Standardized data exchange formats (including Clinical Document Architecture (CDA) support); Transmission via DIRECT Health Information Service Provider (HISP) to the Mass HIway or other partners; Clinical Quality Measure and Automated Measure reporting; and Patient Educational Resource sharing and tracking.

These features support EOHHS's goal of developing secure mechanisms to support data exchange not only with EOHHS and payers, but with the ICC-Engaged Members themselves. By way of example, comprehensive assessments, Individual Care Plans, and other information intended to support transitions of care can be shared via the Patient Portal or transmitted electronically via the Mass HIway. **$21,125** will be utilized to make the above described modifications to Remarkable Health.

4.6 ***Existing Internal Resources will be utilized to support the project*** including existing staff time and expertise in the set-up and training on the new platforms, as well as the on-going monitoring activities associated with effectively deploying and utilizing the new systems, including the COO, SCSA Division Director, ICC supervisors, and EHR and QI/QA director. Additionally, the EHR Remarkable Health is an existing resource to be enhanced to meet the project goals.

4.7. **Evaluation:** Specific Measures to evaluation the completion and impact of the activities will include: Monthly evaluation meetings by the CC supervisors, Freddy DeJesus (Ex/QI Manager and C. Ezzo/Div. Director), and Heather Murphy, agency Evaluation Director. While the agency meets or exceeds the state TOMs and WIFI principles, our goal is to increase the agency's weakest principles (Natural Support Plans and WIFI B-25 by 2 percentage points each by the beginning of BP2. .

Details provided below reflect all above projects.

7. Description of how funds will be allocated across the organization, and SCSA site(s);
Funds will largely be focused on strengthening capacity for effective care coordination within the Springfield/Holyoke CSA. However, many elements will enhance capacity for all CBHI services and also serve to support the goals of the becoming an ACO-CP and LTSS partner. Funding allocation across categories is as follows: *Workforce Development* largely including training contains 19% of DSRIP funds. Both culturally nuanced MI across all levels of consumer contact, and the ARC training are part of an agency-wide initiative that is also supported by other internal funding, and will be open to other clinical/case management staff in other programs as slots are available. *Operational Infrastructure* will support improvements that will largely fund the improvements to the 'front end" through an eHana developed case management package that will sit on our EHR platform contains approximately 69% of DSRIP funds. Technology Improvements including components that will support a "mobile office". This will function as a pilot and it is anticipated that it will provide a model for all of our CBHI services in the future contains approximately 12% of DSRIP funds.

8. Internal evaluation, measurement or performance management strategies:
The program has begun to develop a comprehensive Performance Measurement Plan, informed by the methodologies outlined in Appendix A, and best practices around Wraparound services. A key activity of the Implementation phase will be the finalization of the plan to minimally include the following elements: data collection plan, plan to measure fidelity to the Wraparound model, plan to measure fidelity to CSA policies and procedures (i.e. case notes entered timely, waitlist/ appointments made timely, training and supervision requirements), a quality measurement plan, and a plan to demonstrate effectiveness in the areas outlined in Attachment A of the RFR – Model Contract: relationships with other entities involved with ICC engaged members, relationships with ACOs/MCOs, and contract compliance.

Preliminary planning and existing strategies include the following:
Collection of quantitative and qualitative data: The ***key strategy*** that will be employed to achieve the plan outlined below is the addition of the technology tools and systems defined on pgs.7-8. The addition of the Individual Care Plan into Remarkable Health (RH) EHR will allow for the collection, monitoring, and analysis of the Quality measures described below; enhanced CT reporting including electronic supervision tools will allow supervisors to more easily and efficiently monitor care plan progress, and fidelity to the Wraparound model; and mobile offices will allow direct care staff to complete notes, releases, and safety planning more efficiently. These tools create efficiencies in care coordination, planning and monitoring further ensuring effective service delivery.

The chart below outlines the strategies that will be used to track the additional quality measures found in Appendix A:

Quality Measure	Strategy/method
Prevention and Wellness	**Questions added to ICP:** When was the last PCP well child/adolescent visit? When is the next PCP well child/ adolescent visit? **Excel tracking** of CANS to ensure wellness goals incorporated.
Chronic Disease Management	**Questions added to ICP:** Dropdown menu to identify medical conditions as well as questions to identify when/if follow up is happening regarding these conditions.
Behavioral	**Questions added to ICP:** Current diagnosis/What are the behavioral health goals and

Health/Substance Use Disorder	interventions? Progress on goals from last team meeting. Are there any substance use concerns?
Integration—special emphasis on PCP coordination	**Modification to EHR:** Currently contact notes only have one label, "contact note". The system will be modified to add more descriptive labels including: missed appointment, contact made, PCP visit etc. Additionally, the ability to list care team members will be added to the ICP with category/service sector labels including: PCP, school/educational representative, family member etc. With this in the EHR supervisors will be able to easily pull a report and monitor whether Primary Care Providers are listed as part of the team. The program also notes who is present at each care team meeting.
Avoidable Utilization	**Questions added to ICP**: Were there any emergency department visits/hospitalizations since the last meeting? What was the reason for the visit? What is the plan to address the reason for the visit/hospitalization.
Engagement	The program will undergo an initial baseline assessment of discharge dates compared to intake dates to analyze when people transition out of services i.e. is it during the initial engagement phase? Based on the results the program will develop additional engagement strategies. Additionally, the modification of contact note labels will allow the program to report on missed appointment rates. CC supervisors will monitor these data points ongoing

Enhanced "back-end" reporting from the EHR will be designed by the Quality Improvement Director, and EHR Director working with the Project Team to produce reports on all measures discussed above. The team will identify key report elements and establish regular timelines for pulling reports, and analyzing results.

Member Experience will continue to be measured through the WIFI. As well as a client experience survey designed by GC's Quality Improvement Department. This additional survey includes the following: *Did the Care Coordinator prepare you well for understanding the wraparound process? Did the Care Coordinator both monitor updates relating to your family and keep all team members aware of those issues throughout the ICC process? Do you think that your Discharge Plan will be effective and useful? Do you feel that team members are working well together on behalf of your child and family? In your CPT/TP meetings do you feel that your rights to make decisions as a parent/caregiver are respected? Do you have any suggestions for the program that you would like to share that you think would be helpful?*

Results from the survey will be entered into GC's Intranet system which allows for the aggregation of data collected.

Additionally, the program utilizes the Team Observation Measure (TOMs). The TOMs is administered by any certified observer who has been trained in how to administer the TOM and who has a strong *Wraparound* foundation. Results are entered into the University of Washington Sdata base. Reports are distributed to team annually for review: generated and used: ***1.*** In programmatic development and training with observed staff to promote skill-based supervision; and ***2.*** Aggregate data across all observations are used in planning trainings and identifying and prioritizing group supervision needs. These instruments gather information regarding the programs fidelity to the *Wraparound* model and assess the quality of individualized care planning and care coordination. The results from these instruments are used for program management, training, and coaching to improve the fidelity to the *Wraparound* model.

Staff Responsible:

The Project Manager, in concert with the Director of QI and the project team will be responsible for the overall development and monitoring of the Performance Measure Plan and all elements included therein.

Specific staff responsible for the entry/collection, and validation of data include:
Data Entry:
Intake Coordinators – enter demographic and basic information for client and family at intake.
CCs – enter Individual Care Plan, and Comprehensive assessments with addendums if needed into Remarkable Health EHR; CANS into Virtual Gateway; FT's enter SNCD.
Validation:
CC and FS&T Directors are responsible for reviewing and monitoring all data entered by direct care staff and reporting back to Project Manager.
Executive Manager will be responsible for reviewing and monitoring all data entered by Intake Coordinators and reporting back to Project Manager.

B. Project Team Description:

1. Organizations Chart: (Attachment A) -Gandara Center Organizational Chart and CBHI/CSA Organizational Chart

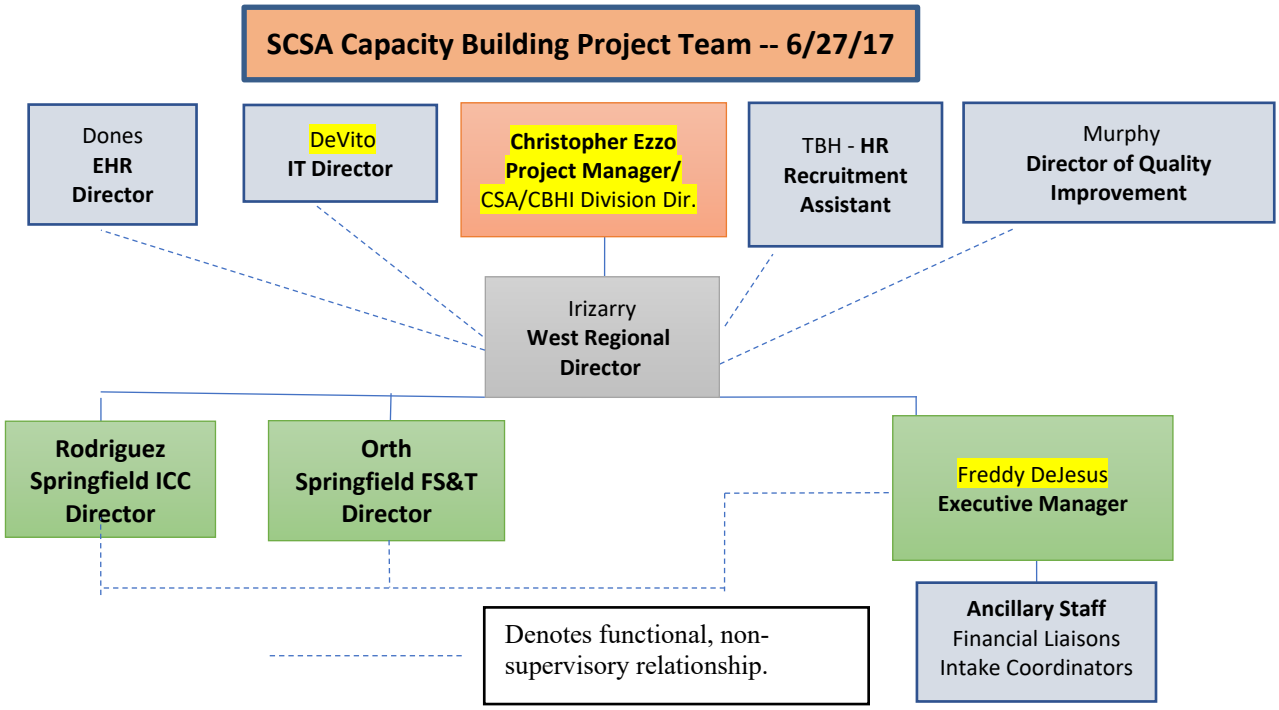
2. Current staff involved in the project: Job descriptions and resumes for the following staff can be found in Attachment B: **Project Manager** Chris Ezzo; **West Regional CBHI/SCSA Director** – Omar Irizarry; **CC Program Director** – Debbie Rodriguez; **Family Support and Training Director** – Abrah Orth; **Executive Manager** – Freddy DeJesus ~~(Job Description only including qualifications);~~ **EHR Director** – Patricia Dones

Ancillary, existing staff that will be involved in implementing the systems-level changes designed by the Project Team. Will not be regular members of the core team. **Financial Liaisons** – Maribel Valentin, Director of Billing & Joannay Torrales, Insurance Specialist **Intake Coordinators** -- Jen Ramos & Kristina Dillon; **Director of Information Technology –** ~~Matt Pasquale~~ Robert DeVito.

3. New staff to be hired or engaged: Approximately 10% of a dedicated ***HR Recruitment Assistant*** will be funded through DSRIP will be located in Puerto Rico (and will recruit in FL & TX), whose role will be to understand the work role and job responsibilities of site based and community outreach outpatient clinicians, CSA clinical supervisors and BA level clinicians, and other mid-level positions for which bi-lingual staff are essential and recruit up to 30 staff annually agency-wide for all clinical/FP positions that require bi-lingual/cultural staff. The assistant will build relationships with Universities and organizations from whom qualified individuals may be recruited, including the development and implementation of a marketing and outreach plan.

4. Staff Roles and Responsibilities: The chart below outlines all members of the project team including their roles and responsibilities as they relate to this project. The Project Manager will

hold primary responsibility for ensuring all efforts are coordinated and not duplicative. This will be achieved through senior administrative support, frequent project team meetings, and on-going monitoring strategies. **(Yellow indicates staff changes since 1st submission)**



Core Project Team Members	Role/Responsibilities – REVISED 11/17
Chris Ezzo – CSA/CBHI Division Director	Primary responsibility for coordination of all activities related to the implementation and day-to-day operations of funding received under this award. Including: Organizing/facilitating project team meetings, set priorities with project team, establish more detailed milestones, benchmarks, policies, protocols and tools sufficient to ensure efforts are coordinated and not duplicative and supportive of the output and outcome measures. Assure submission of all EOHHS reports in accordance with their timelines.
Omar Irizarry – Western Regional CBHI/CSA Director	Responsible for ensuring overall accountability of SCSA project team members. Provides administrative supervision and oversight of capacity building activities.
Heather Murphy – Director of Quality Management	Primary responsibility for developing strategies to measure and track all quality measures as outlined in Appendix A. Interfaces with EHR Director and Project Manager on implementation of measurement strategies. Provides training and TA to staff. Provides Project Manager with regular reports for the purpose of monitoring quality and progress in outlined goals, sufficient to ensure timely submission of all required reports.
Patricia Dones – EHR Director	Oversees and implements all modifications/ additions and enhancements to EHR system, Remarkable Health (RH), in accordance with the timeline. Interfaces with RH developers, GC's Systems Engineer, and QM Director to produce front end user reports for tracking, and data validation. Provides training to staff on CT data entry and TA/ problem resolution for EHR system. Provide documentation of tasks sufficient to ensure timely submission of reports.

Debbie Rodriguez—ICC Program Director	Supervises all Senor Care Coordinators and clinically supervises the Senior Family Partner. Coordinates Systems of care meetings. Responsible for implementing and supporting staff level changes including: changes to data collection/entry, supporting training requirements, works with and provides feedback to the Project Manager around Care Coordination staff level changes as they relate to this project. i.e. enhanced PCP communication protocols.
Abrah Orth – Family Support & Training Director	Responsible for implementing and supporting staff level changes including: changes to data collection/entry, supporting training requirements, works with and provides feedback to the Project Manager around Family Partner staff level changes as they relate to this project. i.e. enhanced PCP communication protocols, additional training requirements.
Executive Manager – Freddy DeJesus	Supervises Intake Coordinators, Billing Systems Administrators, and Training & Systems Coordinator. Responsible for working with EHR, PM to develop Policies and Procedures for all new forms in RH including the ICP and SNCD. Oversees Training Coordinator to ensure training requirements are documented, tracked, and met by all CSA staff. Reports status back to PM. Responsible for working with Intake Coordinators to ensure data entry protocols are met. Provides data validation reports back to PM.
Ancillary Team Memb.	**Role/ Responsibilities**
Fiscal Liaisons: Maribel Valentin –**Director of Billing** Joannay Torrales **-Insurance Specialist**	Will be responsible for implementing any systems level changes as they relate to billing. Will not be a regular part of project team. Support submission of data sufficient to document performance accountability through an at-risk payment model.
Intake Coordinators: Jen Ramos Alizivette Davala	Will be responsible for implementing any systems level changes as they relate to changes in intake data entry, waitlist tracking, or demographic data collection. Will not be a regular part of project team.
Director of IT Robert DeVito	Oversee infrastructure and equipment instillation. Supports interface with external partners.
Staff Recruiter located In Puerto Rico	Recruiter in Puerto Rico to support goal of recruitment of qualified, representative, bi-lingual and bi-cultural staff.

5. Description of project management plan: Chris Ezzo, CBHI Division Director will be the project manager for the project. Key leadership staff (Executive Director, CBHI Services Division Director and Western MA SCSA/CBHI director will attend the project planning team meetings and quarterly meetings thereafter. The project manager will be responsible for convening meetings, setting the agenda, and establishing and tracking and compliance with timelines, including meeting all reporting requirements and deadlines, and follow up tasks sufficient to finalizing and achieve the goals of the Budget plan during the 5-month planning phase, and throughout the 5-year period.

A regular monthly meeting schedule with an established agenda will be set, and based on the Agenda the Project Manager will be responsible for inviting and ensuring that key ancillary team members and the appropriate administrative staff are in attendance based on the specific focus of a meeting and that meeting notes a taken and shared with the team. Workgroup meetings will be established and occur in-between and minimally include: Evaluation, data tracking and QM and Benchmark Accountability Group; Communication Improvement Group: (Network Platform, secure communications and EHR/Case Management platform improvements), and PCP outreach, engagement and education group. Workforce development will occur in the weekly CSA supervisors' meetings and the weekly Group supervision/training meetings. Groups will report back to the team on a monthly basis.

C. Implementation Plan and Timeline: The Activity chart and timeline listed below, outlines the plan for implementing the plan based on the information that we have on hand.

TEAM MEMBERS: Project Manager **(PM):** Chris Ezzo **;** CSA Director **(DD):** Omar Irizarry; Dir. Of Quality Mgmt**(QM):** Heather Murphy**;** Fiscal **(FI);** Dir. EHR **(EHR):** Patty Dones; ICC & FS&T Directors (**PDs**): Abrah Orth & Debbie Rodriguez; Executive Manager (**EM**): Freddie DeJesus	
Preparation Budget Period Timeline (Monthly)	
Time Period	**Activity**
Prep BUDGET PERIOD (1/187-5/18)	
January 2018	COMPLETE Planning phase, tools (protocols & policies, information packets, detailed PCP outreach plan and new data tracking/outcomes policies and tools), EHR modifications and Case Management Platform, Detailed training plan, purchase, train and test mobile "office" equipment. Convene Project Team w/in 2 wks – on-going; Begin Ehana testing Development of Informational Packets for PCP meetings completed Development of the MOU completed Outreach to Pediatric Primary Care Development of relationships with ACO/MCO points of contact Hold initial meetings with PCPs PVIX set-up complete Training Calendar Finalized HR recruiter in place;
February 2018	Purchase and train on mobile office tools
March 2018	Remarkable Health/Ehana modifications finalized Performance Management Plan Finalized
April 2018	
May 2018	Evaluation of Prep. period activities; Planning for Year 1 CQI initiatives and activities; **Submit EOHHS Annual Report of budget period**
Years 1 – 5 Implementation Plan (Quarterly)	
Time Period	**Activity**
Year 1 (6/1/18-5/19)	
Q1	Quarterly Project Team Meeting
Q2	Director of QI and Project Manager produce Evaluation report for Project Management Team and Senior Managers **Submit EOHHS Semi-Annual Report of budget period (date to be specified)**
Q3	Project Team develops plan to collect feedback from PCPs regarding care coordination efforts.
Q4	Project Team conducts planning for Year 2 CQI Initiative and activities.
	W/in 60 days **Submit EOHHS Annual Report of budget period**
Year 2 (6/19-5/20)	
Q1	Quarterly Project Team Meeting
Q2	Director of QI and Project Manager produce year 1 report for Project Management Team and Senior Managers **Submit EOHHS Semi-Annual Report of budget period (date to be specified)**
Q3	Ongoing technology training on the Operational Infrastructure activities of the Prep Budget period. Project Team conducts planning for Year 3 CQI Initiative and activities.
Q4	Additional training on RH as identified through evaluation process
	W/in 60 days **Submit EOHHS Annual Report of budget period**
Year 3 (6/20-5/21)	
Q1	Quarterly Project Team Meeting
Q2	Project Team conducts planning for Year 4 CQI Initiative

	Submit EOHHS Semi-Annual Report of budget period (date to be specified)
Q3	Continuing education and expansion of Care Coordinators knowledge and abilities.
Q4	W/in 60 days **Submit EOHHS Annual Report of budget period**
Year 4 (6/21-5/22)	
Q1	Quarterly Project Team Meeting
Q2	**Submit EOHHS Semi-Annual Report of budget period (date to be specified)**
Q3	Project Team conducts planning for Year 5 CQI Initiative and activities.
Q4	Project Team finalizes sustainability planning for period beyond Year 5 of the project. W/in 60 days **Submit EOHHS Annual Report of budget period**
Year 5 (6/22-5/23)	
Q1	Quarterly Project Team Meeting
Q2	**Submit EOHHS Semi-Annual Report of budget period (date to be specified)**
Q3	Implement Sustainability Plan activities
Q4	W/in 60 days **Submit EOHHS Annual Report of budget period**

D. Budget Report and Budget Narrative (attached) See Attachment C.

E. Sustainability Plan: Gandara Center has developed budgets, (Attachment C) that demonstrate the use of the DISRP funds to build infrastructure and capacity, as described in Section 6.4 - #5 DISRP participation plan. This plan will effectively serve Specialized CSAs (SCSA) current 119 service enrollees, during the DISRP Budget preparation and Year 1, and Years 2-5 of implementation, through the following initiatives that will be incorporated into the SCSA program practices and sustainable thereafter.

Tools/practices developed during the contract term that will support sustainability will include: *Wraparound/Strength-Based Documentation* tools will be embedded into Remarkable Health (RH) EHR platform. This initiative will involve a onetime initial investment. *Care Coordination/Care Management Software Platform: eHana* in collaboration with RH, will create an integrated technology platform to support communication across stakeholders (i.e. EOHHS, ACO, MCO, PCP), including support for the exchange of documentation, as outlined on pgs.8-9. This platform will provide alerts, reminders and prompts for the Care Team actions. This will be developed through the Innovative Care Partners, LLC, which submitted a BH/LTSS Community Partner application, of which Gandara is a partner. This application will involve an initial investment during the budget prep/year one. Only the SCSA portion is included in the budget. *Performance Management Capabilities:* Gandara will develop capacity with its EHR to improve capturing and reporting through daily "data dumps". The Gandara Systems Engineer will develop SQL tools and electronic supervisory tools to aggregate supervision level and event data reporting capacity of all the necessary data tracking for Quality Measures to EOHHS, & MCOs. The two applications will involve an initial involvement for the preparation year and year one. All changes through the DSRIP funding will be sustained by being fully implemented and practices being fully institutionalized by the end of the project period. *Pioneer Valley Information Exchange (PVIX*): Gandara and Baystate Medical Center have signed an MOU to allow the exchange of information between the hospital's information exchange entity, and Gandara. This MOU will provide real time access utilization information/ ER notifications/ inpatient admissions for clients being seen at both organizations. Mobile Office equipment will be a one-time purchase during the Budget preparation period and year one. Gandara assures that

cost allocation of capacity building components will be proportional to SCAS staff, in the event that resources serve other agency programs/projects.

Workforce Development activities such as the clinical staff recruiter of bi-lingual/bi-cultural staff, licensing support and enhanced staff training practices will be sustainable by using a 'train the trainer" approach particularly in the areas of ARC, MI, and the Vroon Vandenberg Tier 1 and 2 integrated Wraparound certifications. The enhanced workforce development activities during the 5 year project period are anticipated to fully meet the referral/ service needs.

Section 6.5 Coordination with ACOs, MCOs, and Primary Care Providers

A. **Plan to improve bi-directional communication with pediatric practices:**
Capacity building funds will support bi-directional community with pediatric practices using the following methods. The Executive Manager will send out an information packet to each area pediatric practice that will introduce the Gandara SCSA and its bi-lingual resources, an overview of the Wraparound process, information on the Intensive Care Coordination and Family Partner option and benefits, eligibility criteria, referral processes, team-based/family driven treatment planning, and Systems of Care meetings/participation. Care Coordinators will identify key practice management staff at each site and schedule informational visits to establish cross-communication practices that will be outlined in an MOU that will be developed for each practice. These will address cross-team critical event information sharing requirements/needs (new client, emergency room visits, mobile crisis, mental health hospitalizations, etc. In pediatric practices in which there is a high volume of Hispanic clients, Gandara will offer the option of embedding an ICC team(s) assigned to the practice to support ease of Care Coordination. New Chart review/supervision, and monthly QI team meetings will support and monitor whether information is being exchanged in a timely manner. The QI/QA team will undergo a NIATX process to ensure that this system is in place. Tools that will support timely exchange of information include the mobile offices; participation in PVIX/secure information exchange, secure email, and upload agreements for key documentation; internal staff training on PCP environments, basic medical terminology, psychiatric medications; and embedding ICC teams in pediatric practices with large numbers of Hispanic clients.

B. Referral management protocols for follow-up and informational sharing;
eHana will develop a Case Management platform to facilitate data exchange with EOHHS, ACO's, MCO's and other stakeholders. Technologies to be used to support case management will include: standards based transactions including ICP over the Mass HIway/DIRECT project; Importing eligibility files and enrollment rosters from EOHHS and ACO's; Bespoke reporting and data extracts in formats specified by EOHHS and ACO partners; Standardized HIPAA billing transactions of Qualifying Activities to EOHHS and Future use of EOHHS Event Notification System of event data integration directly with healthcare stakeholders.

Gandara and eHana will be able to query the complete relational Care Management platform dataset and expect to be able to meet any data reporting/interoperability requirement defined by EOHHS and the ACOs. Gandara will work closely with the ACO partners and its Remarkable Health EHR and eHana throughout the Preparation Budget and year one periods to determine mutually-agreeable datasets for information exchange to improve care coordination efforts.

C. Plan for team-based treatment planning in collaboration with pediatric practices; includes the following 3 steps*: introduction/training* on client driven Individual Care Planning meetings, frequency, expectations, and to establish a process and goals. The Project Manager and ICC Supervisor will identify staff liaisons from pediatric practices to participate in individual care plans planning and best-participation/communication practices and agreements based on individual practice needs/considerations. ICC supervisors will develop tools for staff to fill out and submit in lieu of in-person participation; or option of on-site care coordination meetings at the pediatric site and/or new participation practices; call-in meetings/skype. Additionally, ICC supervisors will provide monthly check in calls with PC practice managers for the first 6 months to identify and discuss challenges, barriers and strategies and at 6 month intervals thereafter.

D. Plan to improve timely access to ICC services: Based on the barriers and challenges identified in Section 6.2.A-B, the Gandara SCSA has identified the following plan to improve timely access to ICC Services. The project team will re-evaluate current access practices (e.g. order of referral), including evaluating criteria and processes for prioritizing access to youth/families for services. The latter will be critical in the event that the ACO/MCO "dumps" a cluster of referrals simultaneously. Recruitment and Retention of bi-lingual/bi-cultural staff continues to be the key barrier to timely access to ICC services. Gandara has initiated an aggressive multilayered plan to address this as follows. Review, modify and implement new interview, screening, hiring, transition support, and training practices for new ICC clinicians recruited from Puerto Rico, Florida or Texas and hiring a recruiter who lives in Puerto Rico. The SCSA will continued implementation and review of retention bonuses for reaching case load milestone, and lengths of stay. The SCSA will initiate a process of anticipatory hiring of new ICC teams as caseloads reach 8-10 families.

E. Plan to improve/increase connections to social services.

Connections to social services and natural community supports is a high area of accomplishment within the Gandara SCSA, as demonstrate by the collaborations chart in Section 6.3.B. However, improvements will be made to outreach, tracking, monitoring and evaluating completeness and follow through among ICC and FP staff. As described above this will include: developing a "back end" mechanism to track and aggregate data by enrollee connections to social services, the addition of consistent individual and group supervision reviews of these connections. Additionally, the ICP has been edited to track all of the quality measure in Appendix A.

Gandara is exploring leveraging social networking tools, such as Facebook Messenger to engage with enrollees. Techniques could include leveraging Facebook's Messenger Platform Application Program Interface to supply enrollee/representative with the Contractor's chat name as well as a unique code, which would automatically associate their Facebook Messenger account with their Care Management record. Enrollees/representative would then outreach to the Care Team at any time via the Messenger app already installed on their phone, notifying their team and prompting real time engagement, providing consents were in place and with necessary checks to ensure no Personal Health Information was exchanged.

Section 6.2 Executive Summary

A. The Bidder's current performance on its Development Plan

All four of JRI's CSAs use the Development Plan as a tool to track both successes and goals for improvement. Current performance across the board is positive with goals reflecting needs relating to increased engagement and team participation, access, care coordination, and quality of documentation. Two of JRI's four CSAs have little to no wait for services, while the other two in the Northeast have clear action plans for increasing access. With the recent merge of the two CSAs from the Northeast's Children's Friend and Family Services Division, JRI's best practices around review and approval of all progress notes and regular chart audits via the electronic medical record system, eHana, lend to continued progress on documentation related goals. Statewide, the area of assessment has been one given recent focus. JRI's assessments are strong per self-audits and review through the Massachusetts Practice Review (MPR). Development Plans detail a Child and Adolescent Needs and Strengths (CANS) completion rate average of 94.5% initially and three-month reassessment rate average of 80.75%. Another trend is that all sites are reporting an increase in "stand alone" Family Support and Training with an average of 10 enrollees each at three of the sites and one of the CSAs, Lynn, reporting 35 families enrolled. Development Plans highlight both needs and strengths and offer opportunities for the four JRI programs to learn best practices from one another.

B. Specific examples of strengths and needs of Bidder

Two clear strengths of JRI's CSAs include ongoing, trauma-informed training for staff and a focus on cultural responsiveness. JRI trains all of its community based teams, including CSAs, in a model called ARC – Attachment, Regulation, and Competency. ARC is a framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress, which is characteristic of many of our families served. In addition, staff actively work on achieving Tier I and Tier II Wraparound Certification. Two of the state's three certified trainers in the evidence based model Achieve My Plan (AMP) work for JRI. Additional areas of expertise and training are shared via both live trainings and webinars on JRI's Learning Management System (LMS). Training is both an area of strength and need in that due to the geographic distribution of our programs, increased technology and infrastructure would support enhanced training and additional opportunities for staff and families served.

With regards to cultural competence, JRI can provide services in multiple languages including Albanian, Arabic, Cantonese, French, Haitian Creole, Khmer, Spanish, Vietnamese, Russian, Portuguese, and Bulgarian. Eighty-two percent of our Lawrence CSA staff are bilingual. Two of the CSAs participated in learning communities with Dr. Ken Hardy, who supports supervisors to work with diverse populations and to elicit open conversations about race and culture. This relates to two other JRI initiatives, the first of which is a focus on reflective supervision across programs and the second is a Cultural Responsiveness initiative with representation from CSAs on its task force. Exploration of health disparities, enhanced training, and support for career advancement of diverse staff are amongst the issues being discussed.

In terms of needs, technology rises to the top of the list and would support enhanced training as mentioned above, as well as increased communication and inclusion of medical providers in the wraparound process, and improved assessment and ongoing documentation. For example, equipping all CSA team members with mobile devices such as tablets would allow for concurrent documentation and access to on-line assessment tools and our Client Assessment

Tracking System (CATS) which gathers clinical outcomes for youth over time and supports improved care.

C. The Bidder's plans for improving timely access to ICC services

The key to timely access is recruiting and retaining high quality staff who meet the diverse needs of our communities served. With the workforce challenges facing the state, JRI is focusing on developing and enhancing relationships with local colleges and universities to expand its workforce. Whenever possible, qualified second year Masters of Social Work or Counseling Psychology students are brought in for their internships. This provides a nine month runway to possible employment following their graduation. During this period, these candidates receive intensive training, shadowing, coaching and supervision which prepares them well for employment upon receiving their degree. Our relationships also create opportunities for our team members to go back to receive their masters degrees at a reduced tuition. JRI has active cost-sharing partnerships with the Simmons School of Social Work and William James College and is exploring additional opportunities for courses with college credit for staff. In addition, each CSA has relationships with colleges and universities in their respective communities which lend to field placements and guest teaching opportunities that expose students to the Children's Behavioral Health Initiative and may pique interest in employment at a CSA. JRI's CFFS/CSA sites have had waitlists for services that will be addressed through the opportunity of adding a full time recruiter position to focus on hiring culturally competent ICC and Family Partner staff to both address waitlist issues and meet the needs of the people we serve in the community.

D. The Bidder's plans for improving care coordination, care planning, and care management for ICC-Engaged Members

Improving care coordination and care planning requires adherence to the roots of high fidelity wraparound and a vigilant focus on the four phases and ten principles. JRI is fortunate to have five master Wraparound coaches who support continued training and coaching of all staff. Active work groups meet regularly for Tier certification in addition to ongoing individual and group supervision. We also have twenty-one Tier II-certified Wraparound specialists.

To improve care coordination and care planning/care management, there are some tangible changes that can be made. Specifically, JRI aims to prepare sites to be accredited as Health Homes via the Joint Commission, improve access to technology for more real-time comprehensive assessment and documentation, and provide additional training opportunities to support an ongoing culture of learning. In the context of health care reform, these steps will align us with the industry and support electronic communication and sharing of health information with ACOs and other community partners as well as equip staff with the knowledge necessary to meet health indicators beyond those that present as purely behavioral.

E. Bidder's plans to improve performance on quality scores and Development Plan goals

While all four of JRI's CSAs score above the national mean per the 2016 Massachusetts Team Observation Measure (TOM 2.0), several strategies are being employed to promote continuous improvement. Per the most recent Massachusetts Wraparound Provider Practice Analysis conducted in 2016, the area of natural supports falls short of the national and state means of 47% at two of our programs. The other two programs, while surpassing this percentage, reach only 54% and 62%. Engaging natural supports in new and creative ways will be key in supporting families in the development of sustainable plans. Strategies such as incorporating the use of ecomaps during all four phases of wraparound, utilizing Absent Partner

Wraparound Participation documents with those who cannot attend meetings, and increasing the use of technology to support participation through phone conferencing, FaceTime or Skype will also be explored. In addition, JRI will use the expertise of our own family partners to coach fellow staff in the incorporation of natural supports based on their own lived experience. This will yield more comprehensive assessments and engagement strategies. A better job at assessment leads to a better job overall.

The CSAs are also actively engaging families in discussions regarding outcome based measures and how they relate to transition planning. Specifically, the Transition Readiness Tool is being incorporated as early in the process as possible and is used as a measure of skills that will be important past the engagement with the CSA, as well as a means for empowering youth and families to watch their progress. This information will be paired with clinical data from JRI's CATS system as well as data gathered through JRI's long-term outcomes project through which outcomes are gathered at designated intervals, months and years following completion of services. Information gleaned from this collective data will be analyzed to inform best practices, highlight training needs, and indicate areas in which quality improvement projects may be targeted. Rapid cycle quality improvement projects utilizing the Plan-Do-Study-Act (PDSA) method are employed to test and apply strategies to support ongoing improvement.

F. The Bidder's plans for improving coordination with pediatric primary care and other physical and behavioral health care providers across the care continuum for youth

Technological advancements, training, and access to nursing consultation will be key to our success in improving coordination with pediatric primary care and other health care providers for youth. Our CSAs share strong relationships with local hospitals and community health centers; however, enhancing our ability to communicate with them in a way that is easy, secure, and manageable for staff will be critical. Our System of Care meetings have been instrumental in building relationships with community partners and can be leveraged as we expand our knowledge of and interaction with health care providers. Many of our local practices are beginning to employ navigators or family care coordinators. Individuals such as these will be targeted for outreach and invited to System of Care meetings and ongoing conversations. Similarly, we will work closely with the Mass. Child Psychiatry Access Project (MCPAP), as this is already a stakeholder with ties to both the behavioral and physical health care provider networks in our communities.

Our psychiatric consultants can assist with "doc to doc" communication which supports the development of new relationships. In addition, funding will be sought to expand consultation to include nursing. This level of expertise will support an expansion of the knowledge base of our staff, development of new training curricula, and establishment of new community partners.

JRI will strive to develop inclusive care planning teams, using technology when necessary to bring healthcare providers "to the table," whether this is in person or via telephone or video conferencing.

Finally, JRI's CSAs will incorporate screening tools which align with other community partners for the early detection of common medical issues as well as substance use. By creating common language that is based on reliable assessment tools, we can more easily communicate concrete concerns to our medical partners. Establishing an ongoing menu of webinars on these topics and assessment tools will further support CSA teams in sustaining enhanced communication and partnerships into the future as well as open up doors for families and youth to access training materials and empower participation in the wraparound process.

Section 6.3 Populations Served and Community Engagement

A. Member populations, service areas and plans to promote health and wellbeing/initiate and maintain engagement

JRI operates four Community Service Agencies (CSAs) that annually help hundreds of families whose children, aged under 21, have been diagnosed with a serious emotional, behavioral or psychiatric condition meeting the federal definitions of serious emotional disturbance and determined through a mental health evaluation to need home-based services. The following table outlines the communities they serve and the service areas covered:

CSA Site	Catchment Area	Community Characteristics
Cape and Islands	Falmouth, Sandwich, Bourne, Mashpee, Barnstable, Hyannis, Yarmouth, Dennis, Brewster, Harwich, Chatham, Orleans, Eastham, Wellfleet, Truro, Provincetown, Nantucket, Martha's Vineyard	Cape Cod and the Islands are largely White communities, over 93%, with a small percentage of Latino, Portuguese and Native American ethnic and cultural minorities. More recently the Cape/Islands CSA has received increasing referrals for Portuguese and Spanish speaking families.
Dimock	The Dimock CSA is located in a historic and dynamic neighborhood of Jamaica Plain. The CSA currently serves youth and families from Allston, Brighton, Brookline, Jamaica Plain, Mission Hill/Roxbury and surrounding towns.	The ethnic make-up of our service population, based on the 2010 Census, includes 38% non-Hispanic Whites, 33% Hispanic/Latino, 20% Blacks, 6% Asians and 3% Other. In addition to English, staff members speak Arabic, Cantonese, French, Haitian Creole, Khmer, Spanish, and Vietnamese.
Lawrence	Lawrence, Andover, North Andover, Methuen	The ethnic make up of the Lawrence CSA service area is as follows: Lawrence is 79% Hispanic Methuen is 89% White Andover is 91% White N. Andover is 94% White. Eighty-two percent of the Lawrence CSA staff are bilingual/bicultural.
Lynn	The Lynn CSA serves Lynn and the surrounding towns of Nahant, Swampscott, Lynnfield, and Saugus. Notable of Lynn staff is their diversity including linguistic and cultural representation of populations served in this gateway city, a home to many new immigrants.	Lynn has a rich industrial history and continues to be a large manufacturing and commercial center. The population of Lynn is 90,329 making it the 9th largest city in Massachusetts. The ethnic make-up of the Lynn community is approximately 57% White, 32% Hispanic, 12% Black, 7% Asian (2010 Census). Lynn is a refugee settlement city and we have new immigrants and refugees arriving frequently.

JRI recognizes the importance of developing positive relationships with a variety of community organizations in order to enrich the lives of and services for people we support, as well as building relationships with organizations that can assist with meeting the needs related to the social determinants of health. Each CSA is deeply rooted in their communities and has a wealth of experience in networking with community resources for services and supports as well as organizing and facilitating community System of Care (SOC) Committees. Through our CSAs and other JRI community based services and programs, JRI staff partners with community programs that serve thousands of youth and families coping with serious and complex medical, behavioral, developmental and mental health needs. JRI's extensive network of community

programs provides us with unique resources to promote the health and well being of the individuals and families we serve. This includes expertise in assessments, screening, case management and referrals; peer support and education groups; evidenced based curricula; mentoring supports; and cultural, social, and recreational activities. JRI programs apply evidenced-based, trauma-informed practices to build family skills and yield measurable outcomes. Intensive Care Coordination (ICC) services use the national High Fidelity wraparound model and Wraparound Fidelity Index (WFI-4) as the primary framework to initiate and engage families in ICC and Family Partner Services, as well as measure satisfaction. JRI is committed to using the evidence-based, trauma-informed ARC (Attachment, Regulation and Competency) framework to help youth and families develop strength and resiliency based competencies that promote their health and well being. The Child and Adolescent Needs and Strengths (CANS) assessment supports JRI's wraparound approach and informs treatment planning to assess life domains in areas of strengths and potential social determinants of health and well being. JRI's Continuous Quality Improvement (CQI) processes, satisfaction surveys, and data tracking systems measure outcomes and enhance service quality and measure health and well being of the people we serve. JRI puts family and peer involvement at the forefront of these processes. Using these, as well as statewide, regional and local partnerships, JRI will continue to support family health and well being through use of our expertise and evidence based practices in care coordination settings, as well as enhancements to our current model described throughout this RFR, including embracing a Health Home Care Model for our CSAs.

B. Relationships within the community to improve the quality of ICC services, including current and planned collaborations and partnerships

JRI CSAs operate local SOC Committees which engage community stakeholders, community providers, business owners, and family representatives to identify community needs and develop plans and systems for resolution. Through this work, and our extensive services and programs across the state, JRI has established strong community connections, all of which provide formal and informal community based supports to the people we serve. Connections through the existing CSA sites and various JRI programs will be integrated, developed and sustained to match MassHealth reform goals to improve the member's experience of care, address population health, and increase efficiency in service delivery. As part of their care coordination role, and through eight years of developing local community relationships, each CSA maintains partnerships with local community health centers, psychiatric and medical facilities, counseling services, crisis teams, and substance use and self-help and advocacy groups. Through JRI programming and the current CSAs, strong partnerships provide families access to public service agencies, including DPH, DHCD, MassHealth, Social Security, TANF, WIC, SNAP, among others in which staff help families to navigate these systems for acquiring benefits and services. JRI also maintains partnerships with educational, vocational and transitional resources, including DTA, local housing authorities, job training and job readiness programs, local educational authorities, educational institutions, and ESL and GED service providers. JRI collaborates with parent and child focused organizations, for assessment and screening, after school activities, day care, mentoring and peer support, and family activities and events. JRI also has an MOU with the Parents/Professionals Advocacy League (PPAL) for training and technical assistance to improve youth guided and family endorsed programming. JRI is also a member of trade organizations including the Association for Behavioral Healthcare, the Children's League and MAPPS which also provides opportunities for sharing resources and information. These existing connections will be used to enhance and explore

resources, network with other community resources and forge new partnerships based on current and anticipated needs of CSA families served, and in conjunction with MassHealth reform. JRI will create new partnerships with ACOs, MCOs, BHCPs, hospitals, community health centers and PCPs, creating a model of facilitated referral and coordination with providers and entities responsible for Total Cost of Care and overall health related outcomes for MassHealth members served.

C. How the current and planned partnerships will align with proposed project(s) described in response to Section 6.4.A.

JRI welcomes the opportunity to strengthen its CSA Services to both maintain fidelity to the Wraparound approach, and advance CSA programming to become a health home model of care. In implementing these initiatives, JRI will develop infrastructures and capacities that will sustain the program over the Contract term and beyond. These structures include Information Technology systems, a Quality Management oversight, a workforce trained in CSA coordination based on a Health Home model, and an organizational governance structure that facilitates the collaboration with ACOs/MCOs BHCPs, LTSSCPs and pediatric practitioners.

JRI recognizes that to best serve Enrollees, CSA CP services must be provided in close partnerships with ACO/MCOs, the entities at risk for Total Cost of Care in the new delivery system. As a result, JRI will build on existing relationships and methods for collaboration with ACO/MCOs, pediatric practices, hospitals and community health centers and invest additional staff resources to further establish current partnerships and develop additional collaborations to newly awarded ACO/MCOs and Community Partners. JRI has extensive experience participating on interdisciplinary care teams and coordinating with a range of providers.

In addition, JRI is prepared to share its specialized CSA service knowledge and other agency expertise with medical providers and care managers within ACO/MCOs and Community Partner Programs. Some examples of this expertise include: ***Trauma Informed Approach***: For 30 years, the Trauma Center at JRI has advanced the field of posttraumatic stress therapy through its leadership role in development, implementation, evaluation, training and educational programs for individuals, families and communities. Each JRI CSA develops a specific trauma plan with oversight from the Trauma Center. JRI also offers comprehensive services and expertise for individuals living with/at risk for HIV/AIDS, mental illness and other disabilities. Services include transitional and permanent housing, mental health and substance abuse counseling, case management, peer support, legal services as well as a center for LGBTQ+ youth. ***Achieve My Plan (AMP):*** JRI has two of the state's three trainers in this evidence based model focused on empowering transition age youth to take the lead in their own care. ***The Positive Parenting Program (Triple P):*** JRI has over 50 staff trained in this evidence based model of parent education and support, which as initiated in Massachusetts by MCPAP. Two staff have been trained in the level called "Primary Care Triple P" designed to interface with medical providers and coach families via four focused sessions. JRI's ***My Life My Choice*** program is a nationally recognized, groundbreaking initiative reaching the adolescents most vulnerable to commercial sexual exploitation. We offer provider training, intervention and prevention services to staff, youth and families, police, and the community at large. In addition, JRI provides training and capacity-building services to non-profits statewide in the areas of strategic planning, diversity initiatives, supervision skills, clinical support and cultural competency. Through our CSA project plans of furthering our IT infrastructure and building staff resources, JRI will be better equipped to offer training and capacity building resources and increase communication and partnership opportunities to system partners including ACOs/MCOs and pediatric practitioners.

6.4 Proposed project(s) and Investment Plan (response not to exceed 15 pages)

Revised 12/20/17

Project 1: Information Technology Services and Capacity Improvement

DSRIP Project Goal(s):

(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members

(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families

(3) Improving timely access to ICC services for children eligible to receive ICC and their families

JRI has substantial demonstrated experience successfully managing implementation, deployment, and support of Electronic Health Records (EHR) and other complex technology initiatives to support the ever changing landscape of performance specifications, quality assurance initiatives, purchaser requirements and changing client needs.

The overarching goals of our IT project plans outlined below supports JRI's practice commitment and research on evidence-based models through data-driven outcomes. This includes assessing the progressive approaches of therapeutic sports and trauma-informed yoga, theater, equine therapy and other arts to approach preventative health and wellness care to the traumatized youth we serve; and use of the ARC framework as a mechanism to improve emotion regulation in youth with severe emotional and behavioral problems associated with trauma histories. For example, JRI has implemented a clinical and behavioral database using a battery of assessment measures to track long and short term outcomes based on service and interventions. Overall the data collected by JRI's internal mechanisms, along with the use of EHRs, guides quality improvement efforts, and helps identify specific risk and projective trajectories for vulnerable youth populations.

Each feature outlined in this plan support EOHHS's goal of developing secure mechanisms to support data exchange not only with EOHHS and payers, but also with the ICC-Engaged Members themselves. JRI's technology goals in each project are related to our commitment to make investments in the areas of interoperability and data exchange to assist CSA's in working with new MassHealth ACOs and other health care practitioners. Each portion of the DSRIP funds allocated to each project outlined below will support enrollment and integration of the CSA programs with the Mass HIway and allow the CSA to interoperate with EOHHS, ACOs, primary care providers, and increase communication and resource sharing with clients and their families. The scope of the IT Infrastructure Strategic Roadmap project comprise of 3 key components/phases that is expected to take 3-5 years to get fully implemented. The components are:

1. CSA DSRIP IT Manager and support staff

2. Development/Adaptation of EHR and/or Care Management System, which includes a) the HyperConverge solution with Fail-Over, Replication and Storage and b) eHana upgrades
3. Upgrading 150 + CSA end user clients including site video conference installation

Project 1/Component 1: IT Staffing -- CSA DSRIP Implementation IT Manager/Specialist

The IT Manager is responsible for the oversight of timelines and for the overall execution of the Information Technology Services and Capacity Improvement project. The IT Manager position has been in place with a 0.60 FTE dedicated to this project since 11/1/17, in order to assess the needs of each CSA site, create a plan for implementation of upgrades, and begin to develop a system for adaptability tests and integration of all related components. The IT Specialist position will be responsible for assisting in the planning, implementation, and outcomes of all projects. The IT Specialist will be dedicated to the CSAs and will assist in execution of data analytics capabilities at the CSA sites and will support the implementation of mobile technology for CSA employees and the installation and operationalization of telecommunications equipment at the 4 CSA sites. The goal of the IT Specialist position is to assist in the planning, implementation and outcomes of above projects. The scope of each project and deliverable is outlined in overall IT plan and individual project plans outlined below.

JRI's deliverables will include development of secure Health Information Technology implementation and development of EHR and agency integration and management of information, allocation of IT project management resources, assistance in execution of data analytics capabilities, secure communication, and mobile technology including tablets, laptops and telecommunication hardware and reporting software for CSA sites.

Use of DSRIP funding: $336,586 over the course of the Prep year and subsequent 5 years. The allocation of funds to the CSA sites will be proportionate to site enrollment.

Evaluation, measurement/performance management strategies: Evaluation of position will be measured by activities outlined in the Technology portion of project plan and implementation plan /timeline outlined in 6.3C

Project 1/Component 2: Development/Adaptation of EHR/Care Navigation System – Implementation of HyperConverge Solution and eHana Upgrades

a) Implementation of HyperConverge Solution

One of the key components of this multi-phase project is to move JRI IT environment to the next generation of technology by migrating to a SimpliVity HyperConverge infrastructure.

The SimpliVity hyperconverged infrastructure is designed from the ground up to meet the increased efficiency, management and data protection demands of today's data-intensive, highly-virtualized IT environments. The SimpliVity solution provides a scalable, modular, 2U building block of x86 resources that offers all the functionality of traditional IT infrastructure—in one device. It assimilates storage; compute; hypervisor; real-time deduplication, compression, and

optimization; along with comprehensive data management, data protection, and disaster recovery capabilities.

Designed to work with any hypervisor or industry-standard x86 server platform, the SimpliVity solution provides a single, shared resource pool across the entire IT stack, eliminating point products and inefficient siloed IT architectures. JRI has chosen the Cisco as its server platform in order to leverage the investment it has already mad on Cisco products for its core network backbone.

The SimpliVity solution is distinguished from other converged infrastructure solutions by three unique attributes: guaranteed data efficiency; built-in resiliency, backup, and disaster recovery; and global VM-centric management and mobility. Three components that are fundamental to JRI's IT Infrastructure Strategic Roadmap for enhancing secure, reliable HIPPA compliant communication with the HIWAY and .interact with the potential of multiple platforms used by ACO/MCO and BHCP/LTSS partners.

The following activities will be performed in completing this component/phase of the project:

1. Planning and Pre-Engagement Preparation
2. Engagement Kickoff meeting
3. Measurement Definition
4. Environment Specification and Build-Out
5. User Acceptance Testing
6. Project Wrap-Up, Findings and Recommendation
7. Project Sign Off

The deliverables for this phase of the project include:

1- VMware vCenter Server for management
2- Network virtual switch installation
3- *Build* document – Documentation for the infrastructure build.
4- Plan and design of a logical architecture for JRI's production implementation of VMware vSphere.
5- Implementation of JRI's production VMware vSphere environment

There is a one-time purchase fee of $233,487 to migrate to a SimpliVity HyperConverge infrastructure. JRI CSAs have been allocated 10% of this total cost, as an appropriate proportion of CSA-related FTEs to total FTEs across the Agency (23,348.70). The goal of this purchase is to provide comprehensive data management, data protection, and disaster recovery capabilities, which will to move the JRI IT environment to the next generation of technology.

b) Electronic Health Record upgrades (eHANA)

JRI utilizes eHana's software-as-a-service (SaaS) Electronic Health Record, which is certified Meaningful Use Complete by Drummond Group (Certification Number 14.04.04.2594.eHan.16.0.1.160728) and is deployed in community-based provider organizations throughout Massachusetts.

The ONC-Certified version of the eHana EHR includes features and functionality intended to support integrated and collaborative models of care, including:

- Patient Portal functionality
- Standardized data exchange formats (including Clinical Document Architecture (CDA) support)
- Transmission via DIRECT Health Information Service Provider (HISP) to the Mass HIway or other partners
- Clinical Quality Measure and Automated Measure reporting
- Patient Educational Resource sharing and tracking

Deliverables: JRI will leverage current and future tools based on eHana's technology platform to support effective communication across all stakeholders, including support for the exchange of essential documentation. eHana's Meaningful Use-certified EHR provides validated support for healthcare interoperability standards and standardized transactions formats. JRI plans to use DSRIP funding to include specific EHR infrastructure and technology investments to fully support the information sharing requirements of EOHHS and ACOs, include custom extracts and integrations from our EHR.

Use of DSRIP Funding: 18,821.60

In kind internal resources include the Director of Quality Management oversight. This includes bi-weekly meetings with eHana, EHR development oversight, training and consultation to 4 CSA sites. Funds will be allocated to CSA sites proportional to the needs and size of the site.

Evaluation, measurement/performance management strategies: JRI has longstanding experience utilizing eHana tools (such as eHana Secure Care Team Messaging, enrollee tagging, QuickNotes, Notifications, and chart exports) and anticipates adopting other technologies (Patient Portal, Real-Time Care Team Chat, advanced interoperability) as necessary to effectively coordinate care. JRI intends to leverage standardized technology frameworks to facilitate data exchange with EOHHS, ACOs, MCOs, and other stakeholders, performance management will be measured based on use and interoperability of both existing tools and new technologies with system partners and funder requirements developed in the future.

Project 1/Component 3: Technology for Service Delivery

In order to upgrade the CSA end user clients, videoconferencing capability will be installed at all 4 CSAs sites. The cost to install videoconferencing capability at one CSA site is approximately $20,000, so it will cost a total of $80,000 for all 4 sites.

To consolidate its end user client computing environment under one robust and portable platform, CSA staff will receive Lenovo computing devices ($1,200 per device). During the prep year, devices will be provided to 75 CSA staff ($1,200 per device * 75 end users totaling $90,000), with the remaining staff receiving devices in subsequent years. All technology upgrades will position the CSAs to interoperate with EOHHS, ACOs, primary care providers, as well as youth and families. In the PBP, the Cape CSA has been allocated approximately $56,666 of the Technology for Service Delivery expense for technology services and capacity improvement, while the Lawrence, Lynn and Dimock CSAs have each been allocated approximately $37,778 totaling the amount referenced above.

Project 2: Nursing Consultation

The goal of the nursing consultation is to foster strong integration among ACOs, primary care providers (PCPs), and ICC engaged members and to strengthen fidelity to the Wraparound process.

Scope: The nurse consultant will assist JRI CSAs in: 1.) communication and collaboration opportunities with primary care practitioners; 2.) developing health and wellness coaching and preventative care curriculum; 3.) providing case consultation ICC care coordinators who have youth enrolled that have complex medical issues, and 4.) assisting in the community mapping process to locate uncaptured local community based programs offering health and wellness initiatives for prevention and chronic disease management as well as other support and self-advocacy groups. The Health and Wellness/preventative care curricula developed will be based on JRI's trauma informed evidence based practices and resourced through professional training literature. It will be a co-training model developed for both staff and enrollees. The curricula will be shared as a provider best practice with other CSAs and with other MassHealth providers as requested.

Deliverables: Given that health and wellness coaching and information regarding symptom management to enable the youth and families we serve to be knowledgeable in the prevention and/or management of chronic medical conditions is so essential, this will be a particular training focus of CSA Care Coordinators in the wraparound framework, and BHH Certification process. Through training, curriculum development, community mapping and consultation, the nurse consultant will help provide ICCs education on how to reduce high risk behaviors and health risk factors such as smoking, substance use, inadequate nutrition and infrequent exercise as well as providing the assistance in accessing parallel health promotion activities. In addition the consultant will assist Care Coordinators in better integrating care particularly for youth struggling with chronic conditions such as asthma, diabetes and obesity. The nurse consultant will help establish better facilitation of both consistent and event based communication among health care entities such as the PCP and staff and the rest of the Care Planning Team.

Use of DSRIP funding: The nurse consultant will be funded part-time at for all 4 CSA sites, totaling $166,108 over the 5 year period.

Internal Resources: In-kind internal resources will include staff training, which will include a 3 day training in year 1 and a one day refresher training during years 2 through 5. Also, internal resources will support supervision of the nurse consultant from the JRI Medical Director, Dr.

Tony Joseph. Should integration of this position be successful in CSAs, JRI will sustain the position for CSAs and as an agency wide resource. Allocation of funds to CSA sites will be distributed evenly throughout the project. As DSRIP funding decreases for the position, the nurse will be allocated to other cost centers for similar training and coordination needs.

Efficacy and performance management will be evaluated by the Wraparound Fidelity Index (WFI-4), Massachusetts Practice Review (MPR), Team Observation Measure (TOM). Both National and statewide statistics from TOM data show >1% participation of medical care providers in Family Team meetings for programs using a High Fidelity Wraparound framework. JRI 's long term outcomes of the integration of a nurse consultant position align with DSRIP fund quality measures including the reduction of unnecessary use of emergency room visits and hospitalizations, increased participation in health and wellness activities, and successful integration of medical providers in family team meetings, as well as increased use of health and wellness and disease management goals and activities in care plans.

The nurse will establish better facilitation of both consistent and event based communication among health care entities, such as the PCP and staff and Care Planning Team. The nurse will dedicate a 0.60 FTE to fostering strong integration among ACOs, PCPs, and ICC engaged members and to strengthen fidelity to the Wraparound process. The nurse will also help JRI CSAs improve resource directories and networks of community-based pediatric practitioners and medical care facilities and will help to build on existing community-based networks to maximize physical/mental health care coordination opportunities. The inclusion of the nurse is essential to creating the systems needed to certify JRI's CSAs to be Joint Commission Accredited community health homes under Behavioral Health Home standards.

Project 3: Human Resources Investment

Goal 1: Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members

Goal 2: Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families

Goal 3: Improving timely access to ICC services for children eligible to receive ICC and their families

Use of DSRIP Funds: Workforce Investment of 3 positions totaling 1.4 FTE for prep period. Total amount over 5 year period $283, 313

Positions and Deliverables

Position 1-- CSA Recruiter: JRI/CFFS has a current employee who is designated as the CSA Recruiter for the 4 CSAs. The recruiter is bilingual and will focus on the demanding need for Spanish speaking ICC and Family Partner staff to support the needs of the diverse CSA communities served. This position has been in place with a 0.8 FTE dedicated to hiring for the CSAs since 9/1/17, with a focus on expedited hiring at each CSA site, in particular the Lawrence and Lynn sites, which have had a history of waitlists.

Position 2 -- Director of Clinical Support and Training: The Director of Training and Clinical Support will develop and implement a training curriculum for the CSA staff that will focus on . the context of health care reform Training curriculum development and refresher will align us with the changing industry trends and equip staff with the knowledge necessary to meet health indicators associated with social determinants of health. In addition training will support electronic communication and sharing of health information with ACOs and other community partners as well as prepare CSA staff to meet Quality Measures outlined in DSRIP funding expectations (Attachment A). The position will also be responsible for directly providing the trainings and will be available for clinical and training-related support as skills are implemented

Position 3 -- Training Coordinator: The Training Coordinator, who has been working on relevant online modules since 11/1/17, will continue to devote a 0.4 FTE to direct training and will also be responsible for learning modules which will allow staff to access online trainings remotely and take refresher courses from any location when needed. JRI's fringe rate of 34.5% is comprised of 12% tax and 22.5% fringes.

Project 4: Quality Management Operational Support

The goal of this project is to provide overall project management, quality management, and oversight for DSRIP funding distribution.

Scope: The scope of work allocated to the Director of Program Development has been in place at a 0.6 FTE since 11/1/17 and will continue to manage overall project deliverables, integrate IT and clinical management of Quality Assurance measures for DSRIP funding and Joint Commission BHH certification, report details of CSA DSRIP plan progress and outcomes to senior executive staff and project management team and coordinate relationship building meetings and activities with ACO's, MCO's, BHCP's, LTSSCP's, community health centers, hospitals and primary care practices. JRI anticipates that ongoing monitoring of systems, goals and relationships will begin to shift to managers and staff of CSA sites, such that the time allocated by the Director of Program Development will decrease each project year Funds will be evenly allocated to CSA sites throughout proposal period.

Deliverables will include CSA program development plans that include successful management and integration of Quality Assurance goals outlined in this RFR, alignment of IT development, system and clinical outcome monitoring, oversight of use of DSRIP funding in meeting and reporting on goals outlined in this project plan. Specifically this will include:

- Assisting CSAs in developing child/family advisory board for each CSA for feedback on improvements and BHH certification
- Identify and integrate required data elements for Quality Assessment in terms of BHH Certification and Wraparound Fidelity.
- Work with EHR vendor to build out data elements and reports in EHR to capture required data for Ql Plan and Performance Measures
- Collaborate with EOHHS, ACO/MCOs to determine reporting of QI/PM and other processes for facilitated referral.
- Assist programs consultants and EHR management to produce internal reports for quality monitoring

- Work with ACO/MCO, MAHealth representatives to create report structures for external reporting QI/QM in relation to Attachment A in RFR.

Internal resources include senior management oversight of the Director of Program Development position; CSA director and supervisor time spent on project, in kind includes lost productivity for supervisory staff implementing project goals. Efficacy and performance management will be evaluated by the Wraparound Fidelity Index (WFI-4), Massachusetts Practice Review (MPR), Team Observation Measure (TOM). National and statewide statistics from TOM data show >1% participation of medical care providers in Family Team meetings for programs using a High Fidelity Wraparound framework. JRI 's long term outcomes of the integration of a nurse consultant position align with DSRIP fund quality measures including the reduction of unnecessary use of emergency room visits and hospitalizations, increased participation in health and wellness activities, and successful integration of medical providers in family team meetings, as well as increased use of health and wellness and disease management goals and activities in care plans. This position will be critical for implementation, operationalization and oversight management of CSA Quality Measures outlined in Attachment A.

b. Project Team description

The four JRI CSA sites have a wealth of experience participating on interdisciplinary care teams and coordinating with a range of providers in their roles providing ICC and Family Partner services, as well as being responsible for community SOC facilitation and coordination. In addition, JRI is prepared to share both their specialized CSA service knowledge and clinical expertise in specialty areas outlined in section 6.3 C, with medical providers and care managers within ACO/MCOs. JRI's Project Management team will be responsible for overall performance and contract management with EOHHS, ACO/MCOs and Members. This team will be responsible for developing operational, qualitative and programmatic elements of the CSA infrastructure and capacity building project plan. As outlined in this proposal these structures and capacities include Information Technology systems, a Quality Management program, CSA sites trained and actively implementing health home models of care coordination that enhance Wraparound fidelity, and an oversight structure that both facilitates the collaboration and strengthened relationships with ACO and MCOs, as well as investments that are sustainable and built into agency infrastructure over time.

An organizational chart is attached. A list of current staff that the Bidder proposes will be involved in the project(s), including their job descriptions and qualifications for the project(s);

Senior Leadership:

Jennifer L. Miguel, LICSW, Senior Vice President

Roody Herold, MA, Chief Information Officer

Stephanie Sladen, LICSW Executive Director of Children's Friends and Service Division of JRI

Deb Oliveira, LMHC, Vice President, JRI

Catherine Mc Dermott, PhD, Director of Quality Assurance

Project Team (Project Team Job Descriptions and Org Chart attached)

Tiffany Naste, LICSW, Director of Clinical Support and Training

Amy Sypher, MA, Program Development Specialist/Project Manager

Binh Tran, LICSW- Director of Dimock CSA

Kristen Bono, LICSW- Director of Cape and Islands CSA

Amy Ackroyd, LICSW- Director of Lawrence CSA

Joy Richmond Smith, LICSW- Director of Lynn CSA

Proposed Positions:

Nurse Consultant

IT Specialist

IT/EHR Manager

Recruitment Specialist

Note: See Attached Project Team Job Descriptions

C. Implementation Plan and Timeline

Prep Period June 2017 May 2018												
CSA Capacity and Infrastructure Building	June17	July	Aug	Sept	Oct	Nov	Dec	Jan18	Feb	Mar	April	May
Staffing and Personnel												
Recruiting and hiring of positions				x	x	x	x	x	x	x	x	x
Project Management team dev/implementation						x	x	x	x	x	x	x
IT Specialist Start								x	x	x	x	x
Nurse Consultant Start								x	x	x	x	x
Training												
Health and Wellness Curriculum Development						x	x	x	x	x	x	x
Implementation training curriculum								x	x	x	x	x
Staff Training Health Home Models of Care								x	x	x	x	x
Electronic Health Record (eHana) Upgrade												
Purchase of block development hours										x	x	x
Training of staff eHana								x	x	x	x	x
ACO Contract and Relationship Development												
Introductory meetings with ACO/MCOs Develop workflows Program Operations	x	x	x	x	x	x	x	x	x	x	x	x
Develop Workflows			x	x	x	x	x	x	x	x	x	x
Program Operations			x	x	x	x	x	x	x	x	x	x
Behavioral Health Home Certification												
BHH CSA needs assessment	x	x	x	x	x	x	x	x	x	x	x	x
Develop BHH policies and procedures								x	x	x	x	x

Update/Maintain local resource manuals								x	x	x	x	x
BHH Certification Preparation	x	x	x	x	x	x	x	x	x	x	x	x
BHH Certification												
System of Care development											x	x
Community HealthCare/Promotion Engagement	x	x	x	x	x	x	x	x	x	x	x	x
Quality Management												
Identify required data elements for QA	x	x	x	x	x	x	x	x	x	x	x	x
Identify EOHHS, ACO/MCOs QI/PM	x	x	x	x	x	x	x	x	x	x	x	x
Produce internal reports for quality monitoring												
Produce reports for external reporting QI/QM												
Information Technology												
Hire IT Consultant/Project Manager							x	x	x	x	x	x
Core Network Upgrade	x	x	x	x	x	x	x	x	x	x	x	x
Upgrade internet installation	x	x	x	x	x	x	x	x	x	x	x	x
SDWAN Solution	x	x	x	x	x	x	x	x	x	x	x	x
Migration to Hyperconverge Solution	x	x	x	x	x	x	x	x	x	x	x	x
Single Sign on Solution (SSO)	x	x	x	x	x	x	x	x	x	x	x	x
ehana Upgrades	x	x	x	x	x	x	x	x	x	x	x	x
Video Conference for sites												
Lenovo laptops												

Budget Period 1 November 2018-July 1 2018	Y 1				Y 2				Y 3				Y 4				Y 5			
CSA Capacity and Infrastructure Building	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Staffing and Personnel																				
Recruiting and hiring of consultant positions																				

Project Management team Implementation																				
IT Specialist	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Nurse Consultant (decrease hours 2-5)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Training																				
Health and Wellness Curriculum Development																				
Implementation training curriculum	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Staff Training Health Home Models of Care	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Electronic Health Record (eHana) Upgrade																				
Purchase of block development hours																				
Training of staff eHana	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
ACO Contract and Relationship Development																				
Introductory meetings with ACO/MCOs Develop workflows Program Operations																				
Develop Workflows	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Program Operations	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Behavioral Health Home Certification	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
BHH CSA needs assessment	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Develop BHH policies and procedures	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Update/Maintain local resource manuals	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
BHH Certification Preparation	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
BHH Certification	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
System of Care development																				
Community HealthCare/Promotion Engagement	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Quality Management																				
Identify required data elements for QA																				
Identify EOHHS, ACO/MCOs QI/PM																				
Produce internal reports for quality monitoring	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Produce reports for external reporting QI/QM	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Information Technology																				
Hire IT Consultant/Project Manager																				
Core Network Upgrade																				
Upgrade internet installation																				
SDWAN Solution																				
Migration to Hyperconverge Solution																				
Single Sign on Solution (SSO)																				
Electronic Health record vendor																				
CSA ehana Upgrades	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Video Conference for sites																				
Lenovo laptops	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Section 6.5 Coordination with ACOs, MCOs and Primary Care Providers

Bidder's specific plans to improve collaboration and coordination with ACOs, MCOs, and primary care providers, particularly pediatric providers, in accordance with ICC performance specifications and in keeping with the goal of improving integration of behavioral and physical health care.

JRI recognizes that to best meet the ICC needs of the children and families we serve, CSA services must be enhanced to work closely with ACO/MCOs and physical health practitioners and both engage and align goals that address social determinants of health with the entities at risk for Total Cost of Care. As a result, and as explained through project plan initiatives, JRI will build on existing relationships and methods for collaboration with ACO/MCOs and Primary Care Providers and invest in additional staff organizational and structural resources as outlined in this proposal to develop deeper associations dedicated to integrating behavioral and physical health care plans, and targeting limited resources toward improved long term outcomes with our system partners.

A. Bidirectional communication between the Bidder and pediatric practices

A recent analysis of the over 6,000 annual encounters between pediatric practices and the Massachusetts Child Psychiatry Access Project (MCPAP) indicates that nearly 30% are requests for care coordination. The CSAs have been designed to deliver this service, yet silos persist between behavioral health and primary care providers and we need to continuously provide community education and raise awareness about the CSAs and other CBHI services.

Bidirectional communication will rely upon overall improved communication and integration to better educate CSAs about primary care needs of youth and educate PCPs about behavioral health needs and resources in the community. With limited time with patients, PCPs must have information at their fingertips that is easy to access and for families to understand. JRI has taken various steps to create a more easily navigable continuum of services and will build upon these initial steps to further improve communication: Concise one-page pamphlets regarding various levels of care; an updated website with a multimedia approach to educating communities about services available; developing opportunities for shared training with ACOs/MCOs/PCPs; better integration of PCPs and new opportunities for ACO/MCO participation in System of Care meetings; the creation of a specific position to assist families in accessing care, a Director of Service Coordination and Navigation; and the development of a Family Advisory Board, which can provide ongoing feedback about ways to improve communication and integration.

With pediatric practices specifically, JRI CSAs will seek mutually agreeable ways to increase communication and integration. This will include an exploration of ways to expedite referral pathways, easy and reliable ways to ensure ongoing communication and sharing of information, and ongoing education.

Per the Program Descriptions and Operations Manual developed for CSAs at the beginning of CBHI, signed releases will be obtained and the PCP will be invited to participate in all CPT meetings. The manual clearly stated that coordinating care with the PCP is required and must be documented. With consent and in collaboration with the family, the care coordinator is encouraged to utilize the Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form.

While this form is used consistently, it generally provides a static, point in time retrieval of information and records. JRI's CSAs and other community based services will seek to enhance this process with actual discussion and shared treatment planning. To do this, our electronic medical records will be upgraded to communicate with other providers and share information

easily. In addition, our staff must have the understanding of common comorbid medical conditions for children and know how they may impact or be impacted by complex behavioral health challenges or multi-stressed family systems. Finally, the issue of travel will need to be negated by the introduction and increased application of telephone and video conferencing. Equipment to support this communication will be needed.

Building upon its culture of learning, JRI will utilize training modules to support increased knowledge of staff to better equip them in initiating informed discussions with primary care providers. We will use our Learning Management System (LMS) to build training modules on relevant topics. Employment of a Nurse Consultant will support this task and also provide the opportunity for nurse-to-nurse or -doctor communication, which will be crucial for families in which there are significant medical needs or information about behavioral health that may be useful in the treatment of that individual and family.

B. Referral management protocols for follow-up and informational sharing

All of our CSAs accept referrals and provide referral resources to/from local pediatricians, schools, behavioral and physical healthcare clinics and providers, EOHHS agencies, courts, police, faith and community based agencies and self referral from families. JRI has the experience to manage high volume referrals from any family community partner. Joint Commission BHH certification requirements in this proposal align with the "Facilitated Referral" Behavioral Health Home recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA). Coordination and integration are essential in the facilitated referral model, requiring that JRI has processes to ensure a high level of coordination of primary physical health care and health promotion activities provided off site. Referral management protocols will continue to be aligned with CSA performance standards, and will continue to be individual-centered, comprehensive, coordinated and integrated, accessible, and performance-based. JRI will develop, in collaboration with each ACO/MCO and health care providers, specific protocols, workflows, policies and procedures, to address the various aspects of collaboration including: referral management; notification of admissions, discharges and ED visits, hospitalizations, and incidents; care planning processes and activities; EHR data sharing; service coordination and support; authorization protocols; and transitions of care.

C. Team-based treatment planning in collaboration with pediatric practices

Challenges in ensuring team-based treatment planning in collaboration with pediatric practices include the time crunch on both disciplines, managing full schedules, multiple appointments, and the need for travel. With improved technology, our hope would be to establish improved opportunities for shared treatment planning. Examples may include use of technology such as FaceTime or phone conferencing. While we will continue to ensure PCPs are invited to the table, whether in person or virtually, JRI's CSAs will also maximize other mechanisms for enhancing team-based treatment planning. Steps as simple as ensuring calls before and after CPT meetings will be bolstered by use of Absent Partner Wraparound Participation Documents. Thorough documentation will be shared across electronic medical record platforms and our nurse consultant will assist in highlighting areas with significant need for collaboration with pediatric practices.

D. Timely access to ICC Services

One indicator of our success is that our four CSAs have had minimal waitlists, and often no waitlist at our Cape and Boston sites. We believe "access delayed is access denied" and make every attempt to immediately provide CSA services, and bridge services if necessary to assure

safety and continuity. JRI conducts regular utilization reviews of all services to determine caseloads, evaluate the medical necessity of services, and respond to changing youth and family needs. We have a task force of senior managers, leaders and QA support staff to support a plan for growth should access become an issue. We are readying infrastructure (IT, financial, maintenance, legal, HR), supervision, clinical resources, and external relationships in preparation. We are known for hiring the best and the brightest. JRI strives to attract highly competent staff with competitive salaries, a top rate benefit package, and a commitment to making the work a career, and not just a job. JRI management is focused on fostering cultural responsiveness and promotes workplace diversity to build a workforce that culturally resembles communities that we serve. This enables our community based service programs to maintain an above industry average of a 60% retention rate.

E. Connections to Social Services

JRI will supplement existing CSA performance expectations that build on its existing connections and partnerships with the local community; focusing specifically on health promotion, specialty care providers for youth managing chronic conditions and primary care practices. As mentioned, these connections are numerous given that JRI is one of the largest non-profits in the state, and our CSAs are deeply rooted in the communities we serve. For example, in Lawrence we have become the lead on a project to address youth homelessness through the Merrimack Valley Consortium and in Lynn, we provide leadership for the local Post-Partum Help Task Force, which includes the creation of a diaper bank, linkage to OB/GYN providers and hospitals, as well as ongoing training. JRI also has over fifteen years of Lead Agency experience in the Southern Region, coordinating care for thousands of youth and families, and working with hundreds of providers and community organizations across the region and the state. Across JRI we have experience with various support and stabilization contracts to assist families with access to social services and a significant strength lies with our family partners and peer mentors, who have lived experience accessing local social services and who provide a uniquely informed perspective in supporting families in establishing connections to address their family's needs. We will leverage our experience with our SOC Framework to engage families and community partners in the CSA model. JRI's outreach plan would expand our scope of social service connections to better integrate health care, wellness and preventative needs for the youth and families we serve.

CSA Budget Report

Justice Resource Institute

Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites	4	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate	NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)	588	588	588	588	588	588	
Estimated Funds	$ 430,512.00	$ 411,600	$ 246,960	$ 176,400	$ 155,232	$ 70,560	**$ 1,491,264**
At- Risk Withhold Rate			5%	10%	15%	20%	
Withhold			$ 12,348	$ 17,640	$ 23,285	$ 14,112	**$ 67,385**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 430,512.00	$ 411,600	$ 234,612	$ 158,760	$ 131,947	$ 56,448	**$ 1,423,879.20**

Investment Projects	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Project 1 Name: Information Technology Services and Capacity Improvement							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 3:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Technology							
IT Staffing including Fringe	$ 68,483	$ 97,288	$ 72,630	$ 43,713	$ 36,315	$ 18,158	**$ 336,586**
Development Adaptation of EHR and/or Care Management System	$ 42,170	$ 37,901	$ 9,744	$ 6,718	$ 5,949	$ 1,228	**$ 103,710**
Technology for Service Delivery	$ 170,000	$ 54,000	$ -	$ -	$ -	$ -	**$ 224,000**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 1 Total	$ 280,653	$ 189,189	$ 82,374	$ 50,431	$ 42,264	$ 19,386	**$ 664,297**
Project 2 Name: Nursing Consultation							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 3:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Technology							
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ 21,856	$ 30,599	$ 43,713	$ 34,970	$ 26,228	$ 8,743	**$ 166,108**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 2 Total	$ 21,856	$ 30,599	$ 43,713	$ 34,970	$ 26,228	$ 8,743	**$ 166,108**
Project 3 Name: Human Resources Investment							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 3:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ 60,603	$ 99,642	$ 51,783	$ 32,280	$ 29,254	$ 9,751	**$ 283,313**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 3 Total	$ 60,603	$ 99,642	$ 51,783	$ 32,280	$ 29,254	$ 9,751	**$ 283,313**
Project 4 Name: Quality Management Operational Support							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 3:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ 30,408	$ 56,804	$ 36,584	$ 27,438	$ 22,865	$ 13,719	**$ 187,818**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 4 Total	$ 30,408	$ 56,804	$ 36,584	$ 27,438	$ 22,865	$ 13,719	**$ 187,818**
Project 5 Name: *[Project title here]*							
DSRIP Goal(s) Addressed: Goal 1:	*Required*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 5 Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 6 Name: *[Project title here]*							
DSRIP Goal(s) Addressed: Goal 1:	*Required*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 6 Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 7 Name: *[Project title here]*							
DSRIP Goal(s) Addressed: Goal 1:	*Required*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 7 Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Project Costs	$ 393,521	$ 376,234	$ 214,453	$ 145,119	$ 120,610	$ 51,598	**$ 1,301,535**
Indirect Costs/ Administrative Overhead Rate 9.40%	$ 36,991	$ 35,366	$ 20,159	$ 13,641	$ 11,337	$ 4,850	**$ 122,344**
Investment Projects Total	$ 430,512	$ 411,600	$ 234,612	$ 158,760	$ 131,948	$ 56,448	**$ 1,423,879**

CSA Budget Report - Budget Narrative Prep Budget Period

CSA Budget Report - Technology - Prep Budget Period

Only complete this infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name: Information Technology Services and Capacity Improvement

DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E-N;*
2 *(2) Strengthening fidelity to Wraparound processes, including the care planning,*
3 *(3) Improving timely access to ICC services for children eligible to receive ICC and*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
IT Manager	$ 80,000.00	0.60	7	$ 28,000
IT Implementation Specialist	$ 55,000.00	1.00	5	$ 22,917
				$ -
				$ -
				$ -
				$ -
Total Salary	1.6			$ 50,917
Fringe rate 34.5%		Total Fringe		$ 17,566
Total IT Staffing including Fringe				**$ 68,483**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

The IT Manager is responsible for the oversight of timelines and for the overall execution of the Information Technology Services and Capacity Improvement project. The IT Manager position has been in place with a 0.60 FTE dedicated to this project since 11/1/17, in order to assess the needs of each CSA site, create a plan for implementation of upgrades, and begin to develop a system for adaptability tests and integration of all related components.

The IT Specialist position will be responsible for assisting in the planning, implementation, and outcomes of all projects. The IT Specialist will be dedicated to the CSAs and will assist in execution of data analytics capabilities at the CSA sites and will support the implementation of mobile technology for CSA employees and the installation and operalization of telecommunications equipment at the 4 CSA sites.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Implementation of HyperConverge Solution	$ 23,348.70
erteva upgrades	$ 18,821.60
Total Development and Adaptation of EHR and Care Management System	$ 42,170.30

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

There is a one-time purchase fee of $233,487 to migrate to a SimpliVity HyperConverge infrastructure. JRI CSAs have been allocated 10% of this total cost, as an appropriate proportion of CSA-related FTEs to total FTEs across the Agency. The goal of this purchase is to provide comprehensive data management, data protection, and disaster recovery capabilities, which will to move the JRI IT environment to the next generation of technology.

The purpose of the erteva upgrades is to improve the electronic health records infrastructure and technology to fully support the information sharing requirements of ECHRS and ACOs, including custom extracts and integrations. The total cost of these upgrades for the CSAs is projected to be *tbd*, with $18,821.60 allocated to the DSRIP award. This upgrade will enhance effective communication across all stakeholders, including support for the exchange of essential documentation in standardized transaction formats.

Technology for Service Delivery

Description of Expense	Cost
Videoconferencing for 4 CSA sites	$ 80,000.00
Laptops for 75 CSA employees	$ 90,000.00
Total Technology for Service Delivery	$ 170,000.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

In order to upgrade the CSA end user clients, videoconferencing capability will be installed at all 4 CSAs sites. The cost to install videoconferencing capability at one CSA site is approximately $20,000, so it will cost a total of $80,000 for all 4 sites.

To consolidate its end user client computing environment under one robust and portable platform, CSA staff will receive Lenovo computing devices ($1,200 per device). During the prep year, devices will be provided to 75 CSA staff ($1,200 per device * 75 end users totaling $90,000), with the remaining staff receiving devices in subsequent years. All technology upgrades will position the CSAs to interoperate with ECHRS, ACOs, primary care providers, as well as youth and families.

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Nursing Consultation

DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E.*
2 *(2) Strengthening fidelity to Wraparound processes, including the care planning,*
3 *(3) Improving timely access to ICC services for children eligible to receive ICC an*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate		Total Fringe		$ -
Total IT Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name: Human Resources Investment

DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E.*
2 *(2) Strengthening fidelity to Wraparound processes, including the care planning,*
3 *(3) Improving timely access to ICC services for children eligible to receive ICC an*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate		Total Fringe		$ -
Total IT Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name: Quality Management Operational Support

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate		Total Fringe		$ -
Total IT Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate		Total Fringe		$ -
Total IT Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate		Total Fringe		$ -
Total IT Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate		Total Fringe		$ -
Total IT Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Workforce Development - Prep Budget Period

Project 1 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate 0.0%		Total Fringe		$ -
Total Workforce Development Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Nursing Consultation

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Nurse	$ 65,000.00	0.41	5	$ 16,250
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0.41			$ 16,250
Fringe rate 34.5%		Total Fringe		$ 5,606
Total Workforce Development Staffing including Fringe				**$ 21,856**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

The nurse will establish better facilitation of both consistent and event based communication among health care entities, such as the PCP and staff and Care Planning Team. The nurse will dedicate a 0.60 FTE to fostering strong integration among ACOs, PCPs, and ICC engaged members and to strengthen fidelity to the Wraparound process. The nurse will also help JRI CSAs improve resource directories and networks of community-based pediatric practitioners and medical care facilities and will help to build on existing community-based networks to maximize physical/mental health care coordination opportunities. The inclusion of the nurse is essential to creating the systems needed to certify JRI's CSAs to be community health homes under Behavioral Health Home standards.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name: Human Resources Investment

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Recruiter	$ 42,000.00	0.90	9	$ 25,200
Director of Training and Clinical Support	$ 90,700.00	0.20	5	$ 7,725
Training Coordinator	$ 52,000.00	0.40	7	$ 12,133
				$ -
				$ -
				$ -
				$ -
Total Salary	1.4			$ 45,058
Fringe rate 34.5%		Total Fringe		$ 15,545
Total Workforce Development Staffing including Fringe				**$ 60,603**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

The recruiter's responsibilities are recruitment of staff for the CSAs. The recruiter is bilingual so as to best support the needs of the CSA community. This position has been in place with a 0.8 FTE dedicated to hiring for the CSAs since 9/1/17, with a focus on expedited hiring at each CSA site.

The Director of Training and Clinical Support will develop and implement a training curriculum for the CSA staff. The position will also be responsible for directly providing the trainings and will be available for clinical and training-related support as skills are implemented. The Training Coordinator, who has been working on relevant online modules since 11/1/17, will continue to devote a 0.4 FTE to direct training and will also be responsible for learning modules which will allow staff to access online trainings remotely and take refresher courses from any location when needed.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate		Total Fringe		$ -
Total Workforce Development Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate		Total Fringe		$ -
Total Workforce Development Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate		Total Fringe		$ -
Total Workforce Development Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate		Total Fringe		$ -
Total Workforce Development Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 1 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate 0.0%		Total Fringe		$ -
Total Program Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate		Total Fringe		$ -
Total Program Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate		Total Fringe		$ -
Total Program Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Director of Program Development	$ 64,595.00	0.6	7	$ 22,608.25
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0.6			$ 22,608.25
Fringe rate 34.5%		Total Fringe		$ 7,799.82
Total Program Staffing including Fringe				**$ 30,408.10**

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

The Director of Program Development is responsible for providing project management and quality management oversight for the DSRIP funding distribution. This position has been in place at a 0.6 FTE since 11/1/17 and will continue to support the attainment of quality the assurance goals, including prevention and wellness, chronic disease management, member experience, integration, and engagement. This position is also responsible for the alignment of IT development, system and clinical outcome monitoring, and oversight of use of DSRIP funding in meeting and reporting on goals outlined in this project plan. The Director of Program Development will integrate all necessary elements of the quality assessment needed for Behavioral Health Home certification.

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate		Total Fringe		$ -
Total Program Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate		Total Fringe		$ -
Total Program Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate		Total Fringe		$ -
Total Program Staffing including Fringe				**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate: 9.40%

Provide a brief description of how the Indirect Cost/Administrative Overhead rate was determined:

JRI's federally approved indirect cost rate is 9.4%. Indirect agency administrative support costs include corporate payroll, fringe, occupancy, accounting, contract management, legal expenses, audit expense, human resources/fringe benefits administration, secretarial support, and corporate and professional liability insurance.

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS March 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
1	Information Technology Services and Capacity Improvement	Implement techonology infrastructure improvements at CSA sites	07/01/17	05/31/18	**Technology**	IT Staffing including Fringe	Designate an IT Manager to oversee the timelines and overall execution of this project.	IT Manager hired.			Hire an IT Implementation Specialist to support the installation and operalization of technology equipment at the 4 CSA sites.	IT Implementation Specialist hired.		
1	Information Technology Services and Capacity Improvement	Improve data management and IT environment at CSA sites.	07/01/17	12/31/19	**Technology**	Development Adaptation of EHR and/or Care Management System	Migration to SimpliVity HyperConverge at 2 of 4 CSA sites.	SimpliVity HyperConverge is operational at 2 of 4 CSA sites.			Migration to SimpliVity HyperConverge at remaining CSA sites.	SimpliVity HyperConverge is operational at all CSA sites.		
1	Information Technology Services and Capacity Improvement	Improve the electronic health records infrastructure and technology.	07/01/17	12/31/19	**Technology**	Development Adaptation of EHR and/or Care Management System	Review and upgrade our current eHana capabilities	eHana upgrade is operational at 2 of 4 CSA sites.			Upgrade of eHana at remaining CSA sites.	eHana upgrades are operational at all CSA sites.		
1	Information Technology Services and Capacity Improvement	Foster strong integration among JRI CSAs, ACOs, primary care providers, as well as youth and families.	07/01/17	05/31/18	**Technology**	Technology for Service Delivery	Purchase of videoconferencing equipment for 2 of the 4 CSA sites	Equipment has been purchased.			Purchase of videoconferencing hardware for remaining 2 CSA sites	Equipment has been purchased.		
1	Information Technology Services and Capacity Improvement	Allow CSA staff to input data in real-time to better serve youth and families.	07/01/17	05/31/18	**Technology**	Technology for Service Delivery	Purchase of laptops for 45 CSA staff.	Laptops have been purchased.			Purchase of laptops for additional 45 CSA staff.	Laptops have been purchased.		
2	Nursing Consultation	Establish better communication among health care entities and maximize physical/mental health care coordination opportunities.	07/01/17	05/31/22	**Workforce Development**	Workforce Development staffing including Fringe	Hire a Nurse to foster strong integration among ACOs, PCPs, and clients.	Nurse hired.			Nurse will work with JRI CSAs to improve resource directories and networks of community-based practitioners and medical care facilities.	Draft of enhanced resource directory will be available.		
3	Human Resources Investment	Expedite hiring of staff at the 4 JRI CSAs.	08/01/17	12/31/22	**Workforce Development**	Workforce Development staffing including Fringe	Identify a bilingual recruiter focused on hiring staff at the 4 CSAs.	Recruiter in place.			Have 3 additional bilingual staff in place at JRI CSAs.	At least 3 bilingual staff have been hired.		
3	Human Resources Investment	Develop trainings to support improved integration of CSA staff with ACOs and PCPs.	11/01/17	12/31/20	**Workforce Development**	Workforce Development staffing including Fringe	Director of Training and Support will have developed a training curriculum for JRI's CSA staff.	Curriculum in place.			Presented 4 trainings to CSA staff.	4 trainings completed.		
3	Human Resources Investment	Create training modules which can be accessed remotely by CSA staff.	11/01/17	12/31/20	**Workforce Development**	Workforce Development staffing including Fringe	Hired Training Coordinator who will meet with CSA PDs to draft plan for and ultimately create remote learning modules.	Training Coordinator in place and draft plan created.			Training Coordinator will have created 3 modules which can be accessed remotely by CSA staff.	3 modules operational.		
4	Quality Management Operational Support	Manage attainment of quality assurance goals.	11/01/17	12/31/22	**Operational Infrastructure**	Operation Staffing including Fringe	Developed assessment of CSA capacity to attain quality assurance goals.	Assessment completed.			Director of Program Development will begin to develop systems to track quality measures.	Draft of systems to track relevant quality measures in place.		

CSA Budget Report

NORTHEAST BEHAVIORAL HEALTH CORPORATION

Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites	2	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate	NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)	223	223	223	223	223	223	
Estimated Funds	$ 192,252	$ 156,100	$ 93,660	$ 66,900	$ 58,872	$ 26,760	**$ 594,544**
At- Risk Withhold Rate			5%	10%	15%	20%	
Withhold			$ 4,683	$ 6,690	$ 8,831	$ 5,352	**$ 25,556**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 192,252	$ 156,100	$ 88,977	$ 60,210	$ 50,041	$ 21,408	**$ 568,988**

Investment Projects	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Project 1 Name: Trauma Informed Care Model Training							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ 52,000	$ 125	$ 125	$ 3,125	$ 125	$ 3,125	**$ 58,625**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 1 Total	$ 52,000	$ 125	$ 125	$ 3,125	$ 125	$ 3,125	**$ 58,625**
Project 2 Name: Technological Upgrades, and Smartphone Connectivity							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 3:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ 68,500	$ 2,230	$ 2,230	$ 2,230	$ 2,230	$ 2,230	**$ 79,650**
Other Technology Expenses	$ 12,500	$ 17,500	$ 30,000	$ 30,000	$ 30,000	$ 30,000	**$ 150,000**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 2 Total	$ 81,000	$ 19,730	$ 32,230	$ 32,230	$ 32,230	$ 32,230	**$ 229,650**
Project 3 Name: Integration, Coordination & Consultation							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 3:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Operational Infrastructure								
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Other Operational Expenses	$ 13,000	$ 21,600	$ 20,000	$ 19,200	$ 13,600	$ 1,600	**$**	**89,000**
Project 3 Total	$ 13,000	$ 21,600	$ 20,000	$ 19,200	$ 13,600	$ 1,600	**$**	**89,000**

Project 4 Name: Marketing to ACOs, PCPs and Communities at Large

DSRIP Goal(s) Addressed:	Goal 1:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*
	Goal 2:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*
	Goal 3:	*Optional*

Technology								
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Workforce Development								
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Operational Infrastructure								
Operation Staffing including Fringe	$ 1,600	$ 2,266	$ 3,943	$ 4,022	$ 4,102	$ -	**$**	**15,933**
Other Operational Expenses	$ 14,500	$ 20,300	$ 12,000	$ 10,000	$ 9,264	$ -	**$**	**66,064**
Project 4 Total	$ 16,100	$ 22,566	$ 15,943	$ 14,022	$ 13,366	$ -	**$**	**81,997**

Project 5 Name: Workforce Retention & Recruitment

DSRIP Goal(s) Addressed:	Goal 1:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*
	Goal 2:	*Optional*
	Goal 3:	*Optional*

Technology								
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Workforce Development								
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Recruitment Expenses	$ -	$ 10,500	$ -	$ -	$ -	$ -	**$**	**10,500**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Retention Expenses	$ -	$ 25,000	$ -	$ -	$ -	$ -	**$**	**25,000**
Operational Infrastructure								
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Project 5 Total	$ -	$ 35,500	$ -	$ -	$ -	$ -	**$**	**35,500**

Project 6 Name: *[Project title here]*

DSRIP Goal(s) Addressed:	Goal 1:	*Required*
	Goal 2:	*Optional*
	Goal 3:	*Optional*

Technology								
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Workforce Development								
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Operational Infrastructure								
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**
Project 6 Total	$ -	$ -	$ -	$ -	$ -	$ -	**$**	**-**

Project 7 Name: *[Project title here]*

DSRIP Goal(s) Addressed:	Goal 1:	*Required*
	Goal 2:	*Optional*
	Goal 3:	*Optional*

Technology

IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 7 Total		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Total Project Costs		$ 162,100	$ 99,521	$ 68,298	$ 68,577	$ 59,321	$ 36,955	**$ 494,772**
Indirect Costs/ Administrative Overhead Rate	15%	$ 24,315	$ 14,928	$ 10,245	$ 10,287	$ 8,898	$ 5,543	**$ 74,216**
Investment Projects Total		$ 186,415	$ 114,449	$ 78,543	$ 78,864	$ 68,219	$ 42,498	**$ 568,988**

CSA Budget Report - Budget Narrative Prep Budget Period

CSA Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name: Trauma Infomed Care Model Tra
DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care planning,*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Technological Upgrades ar
DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care planning*
2 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E*
3 *(3) Improving timely access to ICC services for children eligible to receive ICC an*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Laptops for 50 employees	$ 60,000.00
Portable, electronic signature pads	$ 8,000.00
Care extender applications for smartphones	$ 500.00
Total Technology for Service Delivery	$ 68,500.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:
Laptops for staff will allow more community linkages since the workforce will be mobile. Cost for 50 laptops is $1,200 each for a total cost of $60,000 ($1,200 x 50).

Portable, electronic signature pads for staff in the community allows consent agreements to be signed immediately by family members/guardians and supports quicker access to services. Cost for 40 devices is $200 each for a total cost of $8,000 ($200 x 40).

Care extender applications for smartphones will allow staff to become familiar with the tool to enable clients to use technology to better assist in care management. Cost for 50 applications/downloads at $10 each is $500 ($10 x 50).

Other Technology Expenses

Description of Expense	Cost
Smartphone connectivity for ICC staff	$ 12,500.00
Total Other Technology Expenses	$ 12,500.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:
Smartphone connectivity for ICC staff provides mobile access to workfiles and fosters greater community linkages. Cost for 25 ICC staff is $100 per month for 5 months for 25 devicess ($100 x 5 x 25), or $12,500.

Project 3 Name: Integration, Coordination &
DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E*
2 *(2) Strengthening fidelity to Wraparound processes, including the care planning*
3 *(3) Improving timely access to ICC services for children eligible to receive ICC an*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name: Marketing to ACOs, PCPs a
DSRIP Project Goal(s):
1 *(3) Improving timely access to ICC services for children eligible to receive ICC an*
2 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:
DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:
DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:
DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Workforce Development - Prep Budget Period

Project 1 Name: Trauma Informed Care Model Tr

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate	0.0%	Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Risking Connections training/certification	$ 40,000.00
3 day's salaries, wages, taxes & benefits	$ 12,000.00
Total Training Expenses	$ 52,000.00

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:
Using the train-the -trainer model, LHBS will egnage Risking Connections to provide trauma-informed instruction and certification of an LHBS trainer at a cost of $40,000. This training supports providing ICC using dedicated care coordinators training in Wraparound principles and practices. This training is provided by 2 trainers over 3 full days. The trainers will be available on a consultative basis during the following 12 months to support the trainers who will become certified as a result of the training. This 3 day training will be provided to 47 FTEs within the two CSAs that Northeast Behavioral Health employs. As a result of this training, one FTE will become certified as a trainer of the Risking Connections model.

Three days' salaries , wagess, taxes and benefits for Haverhill CSA staff to attend Trauma Informed Care Model "Risking Connections" Training. This training support providing ICC using dedicated care coordinators trainin in Wraparound principles and practices.

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name: Workforce Retention and Recruitment

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 1 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name: Integration, Coordination &

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Medical consultant	$ 13,000.00
Total Other Operational Expenses	$ 13,000.00

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:
Medical consultant is estimated at 13 hours per month at a rate of $200 per hour for a total cost of $13,000 ($200 x 13 x 5). Medical consultant's role is to review, revise and define clinical quality measures, to review processes , support relationship building with ACOs and PCPs, and to support and coach ICC and Family Support and Training staff on communication with medical providers .

Project 4 Name: Marketing to ACOs, PCPs a

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Director of Communications	$106,496	0.02885	5	$ 1,280.00
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0.02885		$ 1,280.00
	Fringe rate	25.0%	Total Fringe	$ 320.00
			Total Program Staffing including Fringe	$ 1,600.00

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:
Director of Communications creates messaging for use in publications and marketing materials to be used to promote CSA programs with ACO partners, PCPs and the population within the communities that are served by the CSA programs. Estimated time is 5 hours per month.

Other Operational Expenses

Description of Expense	Cost
Printed brochures/collateral mtls	$ 6,040.00
Website redesign consultant	$ 4,500.00
E-mail blasting service	$ 3,960.00
Total Other Operational Expenses	$ 14,500.00

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:
Marketing and communication materials may nclude pamphlets, and other collateral materials as well as social media campaigns and other investments to communicate and promote the activities of the CSA programs within the communities that the CSA programs serve. Costs are estimated based upon need to create and stock materials for use to promote the CSA programs as well as to educate ACO and PCP colleauges regarding the CSA programs. The materials will be translated and printed in various languages representative of the population within the cachement area. The cost will include brochure design, printing and dissemination.

The website resdesign consultant will be engaged to provide enhancements and revisions to the current CSA pages as well as to provide abilty to refer to CSA directly from the website. It is estimated that the cost will be $225per hour for 20 hours of the consultant's time.

The e-mail blasting service will be used to communicate to ACOs and MCOs and other referral partners to develop and maintain strong relationships and partnerships as well as to communicate ongoing programmatic information related to the two CSAs.at $495 per month for 8 months.

Project 5 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate: 15%

Provide a brief description of how the Indirect Cost/Administrative Overhead rate was determined:
The indirect cost/administrative overhead rate is at 15% and includes costs of Human Resources, Finance, Executive Management, Facilities, Purchasing, Information Technology, Compliance & Quality and other administrative employees. LHBS allocates the total pool of its general and administrative costs over the pro-rata incurrence of direct costs by all of its programs (excluding any of the general and administrative departments). The actual experience rate is higher than 15%, but the 15% rate is used since that is the highest rate allowed by Commonwealth of Massachusetts state agencies.

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS March 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
1	Trauma Informed Care Model	Workforce Development through training & certification of CSA staff	12/01/17	12/31/22	**Workforce Development**	Training Expenses	Schedule 3 TIC training for CSAs	Signed agreement with facilitors on scope of work and dates of trainings			Facilitation of 3 day TIC training	Staff attend training, increased awareness of signs/symptoms of trauma		
							Meet with CSA to identify train the trainer	Train the Trainer identified			Train the trainer completes certification	Train the Trainer is prepared to provide trainings to new hire CSA staff		
2	Technological Upgrades and Smartphone Connectivity	Improve technology infrastructure	12/01/17	12/31/22	**Technology**	Technology for Service Delivery	Meet with IT to solidify plan to purchase hardware	Invoice prepared for requested hardware			Hardware purchased	Hardware is ready for dissemenation to staff		
											Creation of training plan for new hardware	Staff are famimliar with new hardware and how to use in wraparound process.		
3	Integration, Coordination & Consultation	Improve operational infrastructure by improving communucation between ICC-engaged members and medical providers.	12/01/17	12/31/22	**Operational Infrastructure**	Operation Staffing including Fringe	Clarify job description and post position for consultant	Position posted on agency website as well as			Candidates interviewed for positions	Selection and hiring of 1 candidate		

PROGRAMMATIC RESPONSE

A Proposal for:
INFRASTRUCTURE AND CAPACITY BUILDING FUNDING FOR COMMUNITY SERVICE AGENCIES

Prepared for:
Commonwealth of Massachusetts
Executive Office of Health and Human Services
One Ashburton Place
Boston, MA 02108

In Response to:
RFR Document #: 17LCEHSCSAICBRFR
Bid #: BD-17-1039-EHS01-EHS01-16727

Submitted by:

Lahey Health
Behavioral Services

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SECTION 6.2. EXECUTIVE SUMMARY

(response not to exceed 3 pages)

THE BIDDER SHALL DESCRIBE ITS DEVELOPMENT PLAN AND STRATEGIES FOR IMPROVEMENT OVER THE NEXT FIVE (5) YEARS, INCLUDING:

6.2.A. THE BIDDER'S CURRENT PERFORMANCE ON ITS DEVELOPMENT PLAN;

LHBS has a development plan for each Community Service Agency (CSA), and have displayed ability to complete tasks and goals by identified timelines. Currently the Cape Ann/Salem CSA is focusing on preparing families for transition and increasing the inclusion of natural supports in care plan team meetings and care plans. This CSA is on the alternative payment methodology pilot. The Haverhill CSA is also working on increasing natural support involvement as well as promoting timely access to ICC and increasing instances of community based activities and services on care plans. Of note, Haverhill recently accomplished goals relating to timely completion of CANS and adherence to TOM observations.

6.2.B. SPECIFIC EXAMPLES OF STRENGTHS AND NEEDS OF THE BIDDER;

The Cape Ann/Salem and Haverhill CSA's have proven an ability to dive into psychosocial experiences and how they have changed the story and the needs for a family. This has been a strength highlighted through the Mass Practice Review (MPR) process, where records have indicated the efforts taken to understand a family in their environment, with a culturally sensitive lens. With a total of 4 MPRs completed last year, assessments and cultural awareness were consistently mentioned as areas of strength. While team formation/engagement has been noted as a need for both CSA, we have specific ICC staff who excel in this area which has been noted in MPR report in the following fashion, "The ICC made herculean efforts to engage all three potential family caregivers (with neutrality despite custody battles) as well as the foster family", which can be leveraged to share best practices with fellow CSA staff. Cape Ann/Salem has recently been invited to share their best practice around timely access to ICC at the next CBHI Level of Care Meeting. ICCs have made observable integration efforts. An example of this is evidenced below:

A persistent ICC volunteers to attend a PCP appointment after being unsuccessful in reaching by phone for care coordination efforts. The identified youth, a 9 year-old female with a trauma history and diagnosed mood disorder has chronic medical issues related to a rigid diet that does not allow for proper nutrition. After hearing the behavioral health concerns the youth and family are currently managing and the extent of the youth's diet the PCP actively engaged in the care coordination process resulting in a proposed planned 30 day admission 24 LOC facility to address the restrictive eating habits. ***With strong collaboration, the team facilitated a planned admission that reduced interruption in education and other sustainable community connections and allowed time to create a clear admission, treatment and transition plan home.***

6.2.C. THE BIDDER'S PLANS FOR IMPROVING TIMELY ACCESS TO ICC SERVICES;

LHBS recognizes that timely access to ICC services is highly reliant on retaining and recruiting the right people in a highly competitive market. We also recognize that retaining the best and the brightest means acknowledging the stress, fears, and worries that can accompany such intense, community based work. We will strengthen current retention strategies with the adoption of a Trauma Informed Care (TIC) model which along with direct benefits to ICC-engaged members aims to prevent and identify early warning signs of vicarious trauma and burnout. Retention will support consistent timely access to services for eligible members. We will leverage our current HR systems along with additional DSRIP funding to support strong recruitment strategies for CSA related vacancies.

In addition to our efforts to retain and recruit highly qualified staff, we will ensure the workforce closely monitors medical necessity through a trauma informed lens to guarantee that the right member is enrolled in the right level of care at the right time. Lastly, by addressing a major underlying need such as trauma, we hope to reduce the number of re-admits by creating the most sustainable plans for ICC-enrolled members.

6.2.D. THE BIDDER'S PLANS FOR IMPROVING CARE COORDINATION, CARE PLANNING, AND CARE MANAGEMENT FOR ICC-ENGAGED MEMBERS;

The CSA's will leverage current Google Suite (G-SUITE) applications and upgraded hardware for live care planning with increased remote participation possibilities during critical moments of care such as ED visits, avoidance of and admissions to higher levels of care and transitions in care. When considering the example mentioned above in 6.2.b, G-SUITE and updated hardware would have allowed that process to be more proactive and efficient with real time care planning with care plan team members who may not have been able to participate in person with such short notice, or those struggle to attend meetings offsite. With a simple invite from their Google Calendar, an ICC creates the opportunity of remote video participation for care plan team members. Members need only to click a link included on the invite for the video participation to begin through Google Meet. Care coordination and management will be further enhanced by offering members the use of a health and wellness application, or "care extender app", on their smartphones to improve outcomes relating to preventative care, such as wellness appointments through the primary care physician and the dentist. Given the prevalence of families who have smart phones or tablets, the "care extender app" will also support follow through of assigned CPT tasks for youth and families such as those related to overall health and wellbeing like keeping a log of daily moods or partaking in recommended chronic medical care treatment. This app also aims to support youth and families focus on their goals as listed on their Care Plan.

6.2.E. THE BIDDER'S PLANS TO IMPROVE PERFORMANCE ON QUALITY SCORES AND DEVELOPMENT PLAN GOALS; AND

All efforts funded through DSRIP funding aim to improve performance on quality scores and development plan goals. Please see below for a description of plans for each quality measure:

Quality Measure	Need addressed	Plan
Prevention and Wellness	• Timely communication with PCP's and other medical systems • Increase outreach to medical providers	• Communication with PCPs to ensure members are up to date with preventative and wellness screenings/services • Provide reminders to engaged members and troubleshoot any barriers to follow through. Explore the use of a "care extender app" to

		assist in this strategy • Medical consultant will participate in marketing plans to ACOs and other medical providers relevant to youth served in order to increase awareness of preventative appointments and interventions.
Chronic Disease Management	• Awareness of member's chronic medical conditions • Understanding of diagnosed chronic diseases and potential for care planning around said needs. • PCP awareness of how care planning can support management of chronic diseases and overall member wellness	• Engage in increased bi-directional communication with PCPs and ACOs to include medical needs on ICP • Leverage project medical consultant to participate in marketing plan to further education PCPs and ACOs on CSA's ability address medical needs in care planning process. • Build on current secure messaging and upcoming EHR rollout to support communication.
Behavioral Health/Substance Use Disorder	• Low attendance for urgent care plan team meetings. • Difficulties reaching Care Plan Team members by phone during moments of high acuity.	• Notify care plan teams through secure messaging when a youth has been admitted to a higher level of care for a BH/SUD need. • Leverage "G-SUITE" application allowing for care plan team member remote participation during emergency CPT meetings with improved hardware and mobile connectivity through Google Meet video participation.
Member Experience	• High prevalence of youth and families experiencing chronic trauma or stress with potential for trauma re-enactment. • Achieving high fidelity to model with new staff • Barriers to follow through with assigned tasks or goals. • Impacts of vicarious trauma and burnout on the overall Warparound experience.	• Adopt a sustainable TIC Model to ensure consistent universal precautions are taken with all ICC-enrolled members. Ensure the underlying need of trauma is identified early on in care planning process. • Maintain opportunities for staff to gain Tier 1 Wraparound certification without use of DSRIP funds to ensure high fidelity Wraparound • Increase opportunities for "customer satisfaction surveys" that allows for feedback on technology enhancements as well as identification of barriers to engagement. • Create action plans to address needs identified in surveys
Integration	• PCP Responsiveness to CSA communication • Integration of medical needs into ICP	• Leverage a medical consultant to improve integration and overall communication. • Incorporate use of "Care-extender" application to support attendance of preventative appointments and other tasks related to routine

		medical and/or behavioral healthcare as well as follow through on potential ICP assigned tasks. • Establish lines of communication with ACO's and pediatrician offices to increase engagement of PCP in care plan teams.
Avoidable Utilization	• Logistical struggles around scheduling urgent care plan team meetings due to CPT member availability. • Lack of mobile connectivity for flexibility of meeting location.	• Build on current proactive safety planning to increase utilization of remote participation for care planning during urgent moments where short notice is provided. • Continue meetings with MCI to avoid admissions to higher levels of care when possible. • Work with ACOs and PCPs to identify and monitor high ED utilizers who are eligible for ICC.
Engagement	• Consistent updating and dissemination of Care Plans	• Revise current record review tools and leverage the EHR to ensure adherence to an updated care plan at least quarterly that has been viewed by a PCP or other medical provider. • Increased frequency of customer satisfaction surveys. • Collaborate with PCP offices and ACO's to plan face to face visits at medical appointments when ICC may be clinically indicated.

6.2.F. THE BIDDER'S PLANS FOR IMPROVING COORDINATION WITH PEDIATRIC PRIMARY CARE AND OTHER PHYSICAL AND BEHAVIORAL HEALTH CARE PROVIDERS ACROSS THE CARE CONTINUUM FOR YOUTH.

Improving coordination with pediatric primary care and other physical and behavioral health providers across the continuum of care for youth will be achieved through actions at a variety of levels within the organization:

Level	Action
Community	Involvement of System of Care Meetings to ensure strong collaboration and increased awareness of integration. Continued attendance at community stakeholder meetings.
Systems	Regular meetings with leadership from ACOs and other physical & behavioral health care providers to proactively discuss coordination. Targeted marketing to PCP and other Physical and Behavioral Health Care Providers to increase awareness of services provided.
Individual members	Bi-directional communication with providers through the use of secure data sharing that meets the needs of the model contract Meetings with program leadership and offices when challenges in collaboration are identified that are not solved by the ICC and care plan team.

SECTION 6.3. POPULATIONS SERVED AND COMMUNITY ENGAGEMENT

(response not to exceed 3 pages)

The Bidder shall:

6.3.A. DESCRIBE THE MEMBER POPULATIONS AND COMMUNITIES IT SERVES, THE REGIONS OR SERVICE AREAS COVERED (AS APPLICABLE), AND HOW IT PLANS TO PROMOTE THE HEALTH AND WELLBEING OF THE INDIVIDUALS IT SERVES AND ACTIVELY INITIATE AND MAINTAIN ENGAGEMENT WITH THEM;

In alignment with ICC specifications, the CSA's engage members age 0-21 who meet the criteria for Serious Emotional Disturbance from a variety of backgrounds including but not limited to: socioeconomic level, race/ethnicity, sexual orientation, gender identity, and family make up. The CSA's have displayed an average capacity of over 200 members. This engagement will be maintained and enhanced by a trauma informed approach with a clear commitment to cultural awareness for a youth and family to ensure that service delivery is in alignment with their principles and values. Engagement will be maintained by using and leveraging current efforts:

- Frequent solicitation of feedback through formal surveys and informal discussions,
- Ongoing weekly contact with the member at minimum
- Enhanced training efforts to bolster engagement skill with our most challenging to engage members.

LHBS is committed to supporting and coordinating services with and on behalf of members with high behavioral health needs through collaboration and in partnership with clinicians, providers, ACO and MCOs. Our model is designed to integrate all services and achieve the triple aim: improve the quality of life for members, improve their health outcomes and reduce cost.

LHBS has a strong foothold in the Northeast Region with two Community Service Agencies that are each co-located with a variety of other youth related community based services. The CSA programs serve the following communities which include other LHBS programs that are co-located to further support members:

CSA NAME	COMMUNITIES	CO-LOCATED PROGRAMS
Cape Ann/Salem	Beverly, Salem, Hamilton, Wenham, Essex, Gloucester, Rockport, Peabody, Danvers, Middleton, Marblehead	Outpatient, Psychiatry, In Home Therapy, Therapeutic Mentoring, Student Assistance Program, Team 14 (A-CRA), Individual & Family Flexible Support Services (DMH), Mobile Crisis Intervention (MCI), FIRSTeam (DCF)
Haverhill	Amesbury, Boxford, Georgetown, Groveland, Haverhill, Ipswich, Merrimac, Newbury, Newburyport, Rowley, Salisbury, Topsfield, West Newbury	Outreach Outpatient, Individual & Family Flexible Support Services, In Home Therapy, Therapeutic Mentoring, Team 14 (A-CRA) Mobile Crisis Intervention (MCI)

Both CSA's experience similarities relating to the level of diversity in the communities served. Our CSA staff recognizes the unique culture of each town served. In Cape Ann/Salem, ICCs recognize that Gloucester, for example, is known for its "fisherman" culture. This prompts CSA staff to use creativity to maintain engagement with caregivers or natural supports that may be gone for weeks at a time for work. Those residing in town consider it an, "Island", where some of its residents have never crossed over the bridge to the "mainland". This speaks to the closed culture that presents in

Gloucester who is heavily impacted by substance use. Communities such as Marblehead, Wenham, Hamilton and Middleton present as more middle class communities where a common challenge is engaging members to identify a substance use or mental health concern. Once that barrier is addressed, another common barrier is the stigma that prevents families from wanting to openly discuss their needs with teams and more specifically natural supports. This CSA is accustomed to avoiding Salem during the month of October, but recognizes how this piece of the culture resonates with its residents. Staff has become better versed in topics such as Wiccan. This community is more urban with youth who may have more court involvement and potential for gang involvement. Culturally, we identify that this region tends to have more youth involved in probation versus DYS. This differs from the Haverhill CSA, where parents are hesitant to seek Child Requiring Assistance (CRA's) due to the potential for youth to become DYS involved. Per the Haverhill DCF Area Director, this area is "disproportionately impacted" by the opiate crisis with its caregivers and youth. Due to this, and the dramatic increase of 51-A's in for this area, we see higher risk needs presented in homes. This has prompted the CSA and DCF office to more intentionally collaborate proactively recognizing the level of stress and risk that both teams see in the community. Similar to Cape Ann/Salem, there are more affluent communities served such as Boxford, Newburyport and Newbury, where a major barrier is acknowledging the existence of mental health and substance use needs. For youth who do present with significant needs, they must also manage the stigma in a community that may be not be accepting of mental health and substance use needs. While this is a need across the state, Haverhill CSA feels a greater need for child prescribers and outpatient therapists recognizing that waiting for such referrals to be assigned has impacts on the transition process for families.

6.3.B. DESCRIBE RELATIONSHIPS WITHIN THE COMMUNITY IT WILL LEVERAGE TO IMPROVE THE QUALITY OF ICC SERVICES, INCLUDING CURRENT AND PLANNED COLLABORATIONS AND PARTNERSHIPS WITH FAMILY ORGANIZATIONS, SCHOOLS, CHILD-CARE PROVIDERS, COMMUNITY-BASED ORGANIZATIONS, YOUTH SERVICE ORGANIZATIONS, ADVOCACY GROUPS, BEHAVIORAL HEALTH SERVICE PROVIDERS (INCLUDING PROVIDERS OF OTHER CBHI SERVICES), CHILD-SERVING STATE AGENCIES, TRIAL COURTS (INCLUDING PROBATION, COURT CLINICS, AND JUVENILE DIVERSION PROGRAMS), HOUSING/SHELTER PROVIDERS, AND SOCIAL SERVICE ORGANIZATIONS; AND

For 60 years, LHBS has been a community provider of a robust continuum of BH services in the northern region in the communities and service areas in which we operate our two CSAs. As such, LHBS is well positioned to leverage community relationships to improve the quality of ICC service. Please see below for current collaborations:

Category	Name
Recreational	YMCA, Project Adventure, Recreational Department, Boys & Girls Clubs, BCLC, after school programs, summer camps, sports leagues
State Agencies	Department of Children and Families (DCF); Department of Mental Health (DMH); Department of Youth Services (DYS), Department of Developmental Services (DDS), Department of Early and Secondary Education (DESE); Department of Transitional Assistance (DTA)
Education	Public School systems, Therapeutic Day Schools, Private schools, Headstart
Health care	PCPs, community hospitals, ACO's
Behavioral Health	Outpatient clinics, Other CBHI services, Inpatient facilities, CBAT Facilities, Partial Hospitalizations, Residential facilities, Adolescent IOPS

Housing	Shelters, housing support programs, local public housing entities
Community-based organizations	Local chapters of NAMI, PPAL, faith based groups, food pantries
Law Enforcement	Local police departments, juvenile courts, court clinics, JDAI
Advocacy Groups	Children's Law Center of Massachusetts, Disability Law Center, Federation for Children with Special Needs, Special Needs Advocacy Network, North Shore ARC

As evidenced by the table above, LHBS believes in the importance of engaging and maintaining collaboration with agencies and other community partners where our members spend their time and where they receive their care. An example of this is a recent collaboration with the North Shore YMCA- a facility where many of our youth and families visit for recreational activities. We will provide education to their staff to ensure awareness of the signs and symptoms of youth mental health, substance use and trauma. LHBS will leverage its two current Systems of Care and associated relationships to improve the quality of ICC services including the attendance of medical professionals at least quarterly to promote the overall health and wellbeing of the community and its members. To continue to collaboratively identify and strategize ways to meet the needs of the members and the communities, the Committee will take time to identify and address gaps in community resources that impact the overall health and well-being of the youth and families we serve.

LHBS will continue strong collaborations with the DCF, DYS and DMH. Having state contracts has supported these relationships and provided members with seamless transitions to and from insurance and state funded services. The CSAs have standing monthly meetings with the DMH and the DCF to discuss mutual youth and families. LHBS and the CSAs are committed to continuous quality improvement and evolution of services to meet the needs of the population we serve. We hope to show key stakeholders and community partners that we are committed to this with plans to initiate similar meetings with other state agencies and foster a relationship that supports consistent attendance at our System of Care.

We will leverage our extensive history of collaboration with the MCO's and hospitals operating in MassHealth's northern region. As an Emergency Services Provider for over 20 years, we have provided emergency services to 10 Emergency Departments in the Northeast. Over the last three years, LHBS has partnered closely with Lowell General under the CHART Grant Program to reduce 30-day ED "re-visits" by providing care coordination to members. LHBS has gained additional experience coordinating with hospital systems through the Hear For You Program with NHP that lead to better outcomes with members. We will build on these successes by increasing communication to sustain awareness of our capacity to provide high-quality care coordination to youth in the northeast region. LHBS will hold in person meetings with ACO leaders to support the goals of the ACO and LHBS.

6.3.C. DESCRIBE HOW THE CURRENT AND PLANNED PARTNERSHIPS DESCRIBED IN RESPONSE TO SECTION 6.3.B ALIGN WITH THE BIDDER'S PROPOSED PROJECT(S) DESCRIBED IN RESPONSE TO SECTION 6.4.A.

Current and planned partnerships demonstrate our commitment to taking a holistic approach to treating the whole person. By incorporating a medical provider as a consultant with DSRIP funds in the System of Care meetings, we will have ensured integration at a macro level with a community impact. Strengthening our existing relationships with medical providers will support our efforts in increasing integration and care coordination. With the training of ICC staff through a yearlong

curriculum on chronic diseases and integration supplied by MassHealth, the workforce will be prepared to provide strong integrated care coordination.

Our long standing relationships with state agencies provide an understanding of the needs of the populations they serve. Specifically, our relationship with DCF and DMH and our existing internal contracts supports our members who need additional support outside of insurance based services including the ability to access afterschool, weekend, and summer programming to avoid higher levels of care. This allows for seamless transitions and face to face handoffs between state contract and insurance funded services. Being under the umbrella of LHBS and being co-located allows for strong coordination of care and close communication that will be further enhanced by technology improvements. One consistent theme across child serving agencies is the prevalence of chronic stress and trauma. With the adoption of a TIC model, LHBS will continue to enhance the treatment of our most complex members as well as improve retention of our best and brightest through the reduction of secondary or vicarious trauma and burnout.

SECTION 6.4. PROPOSED PROJECT(S) AND INVESTMENT PLAN

(response not to exceed 15 pages)

6.4.A. PROJECT DESCRIPTION (PROGRAM NARRATIVE)

For each project the Bidder proposes to implement with funding received under the Contract, the Bidder shall provide the information requested in Sections 6.4.A below. The Bidder shall provide an abstract for each proposed project, including:

LHBS intends to engage in 5 projects with the use of DSRIP funds to improve the member experience and quality of service delivery. We propose to improve our operational infrastructure by (1) strengthening integration at a variety of levels from individual members to the communities we serve with the support of a consultant from the medical field. In order to do this, we recognize that we must invest in our workforce by allowing for (2) training and certification of a TIC model to enhance the member experience, and prevent burnout and vicarious trauma with CSA staff. To further enhance the overall member experience and the coordination of care LHBS proposes to invest in (3) hardware and connectivity updates as well as the potential member use of "care extenders" to ensure that members are thinking of their overall health well-being outside of the presence of providers. These upgrades also aim to improve the care planning process, specifically removing barriers to team members with inflexible schedules or inabilities to attend offsite meetings, such as doctors. We will use a (4) targeted marketing plan to further engage ACOs and PCPs and communities at large to ensure familiarity with CSA services as well as how medical needs can be addressed through the care planning process. Lastly, LHBS will invest in (5) recruitment and retention activities to ensure timely access to ICC with high fidelity Wraparound by retaining our best and brightest staff.

A project abstract for each of the 5 proposed projects is provided below.

1. Project 1 Name: Integration, Coordination & Consultation	
2. Project Goal & Plan to Meet Goals:	
Improve Operational Infrastructure by improving communication between ICC-engaged members and Medical providers.	Hire a medical consultant to improve procedures and workflows to enhance integration of care Participate multidisciplinary reviews of our most complex ICC-engaged members Strengthening relationships with medical providers Increase medical professional attendance at System of Care Meetings for community impact

3. Project Scope, Method and Activities:

The goal of the Integration project is to address needs relating to communication between behavioral health providers and medical providers and integration of medical needs into the care planning process. This project aims to ensure that care plans promote behavioral and medical well-being in alignment with a youth's specific behavioral and medical health providers. LHBS recognizes the immense need for integrated, whole person care for individuals with SMI, SUD and chronic medical issues. We aim to enhance our workforce knowledge of integration and develop systems and workflows of structured communication and a multi-disciplinary team approach to care. This will be achieved through the efforts listed below:

- Protocols that identify planned points of contact throughout treatment with identified ACO's and/or primary care offices.
- Highlighting medical needs into Care Plans
- Implement a standard wellness tool with guidelines for appropriate next steps in coordination
- Identify a "Care Extender" application to support follow through with preventative appointments as well maintenance of chronic medical and behavioral health needs.
- Medical staff present for consultations, multidisciplinary reviews of care plans, support in troubleshoot communication challenges with medical providers
- ICC to engage in more activity around notification/management of medical and behavioral health appointments including ED notifications

The CSA's will demonstrate targeted enhanced integration by hiring a medical provider as a consultant and member of the project team throughout the 5-year project duration. This medical consultant will be most heavily involved during the prep and year 1 budget periods tapering off each year thereafter. Please see the proposed methods and activities listed below:

Budget Period	Use of Funds received	Methods/Activities
Prep	Medical Consultant Care extender App Marketing plan and materials	• Identification of a health & wellness screening tool to use with ICC-enrolled members at prescribed times during service delivery. This will include development of procedure and workflow for when communication with PCP and/or ACO is indicated. • Identification of a "care extender" application that supports the strengths and needs of the community to enhance the member experience (actual roll out is noted in "Technological Upgrades"). • • Targeted marketing to ACO/PCPs • Support increased communication between PCPs and ICCs
Year 1	Medical consultant	• Strengthening relationships with current medical providers to improve care coordination and develop a network of medical providers who will attend System of Care Meetings. • Development of quarterly training and/or discussion topics for System of Care Meetings with potential to leverage G-SUITE for remote attendance/participation of SOC attendees. • Roll out of health & wellness screening tool to workforce with protocol sign off relating to frequency of use and scores that indicate action steps that must be documented in the medical record • Project Team will revise internal record review tools to assess for integration efforts. • Medical consultant to attend the agency's "Cross Divisional High Risk Meetings" to provide insight to our most medically complex ICC-

		engaged members.
Year 2	Medical consultant	• Medical consultant will collaborate with Director of BHCP for improved communication and breakdown of silos to ensure that the care of ICC-engaged members and their families have improved coordinated care. • Quarterly presentations at System of Care meetings • Initiate quarterly multidisciplinary reviews of medical records and Intensive Care Plans with medical consultant. • Available for consultation with workforce for our most medically complex youth. • Ongoing attendance at the agency's "Cross Divisional High Risk Meetings" to provide medical insight to our most complex ICC-engaged members.
Year 3	Medical consultant	• Ongoing collaboration with ACOs and pediatrician practices • Ongoing participation in quarterly multidisciplinary record and Intensive Care Plan reviews in CSA's to assess progress • Ongoing availability for consultation with workforce for our most medically complex youth and attendance at the agency's "Cross Divisional High Risk Meetings" to provide medical insight to our most complex ICC-engaged members. • Quarterly attendance at System of Care meetings, identification of "co-facilitators" for medical presentations
Year 4	Medical Consultant	• Previously listed ongoing tasks • Assess any needs relating to sustainability
Year 5	Medical consultant	• Address any needs relating to sustainability including communication with ACOs and PCP • Previously listed ongoing tasks • Identify current existing medical professional to attend the agency's "Cross Divisional High Risk Meetings"

4. Deliverables- Project 1 Integration, Coorindation & Consultation

- Hiring and onboarding of a medical consultant
- Institution of a health/wellness screening tool with associated protocols
- Updated internal record review tool that assess integration efforts
- Established lines of communication with ACO's and PCPs

Increased integration at System of Care meetings

5. Use of DSRP Funding:	
$89,000	LHBS will invest this money in hiring a medical professional consultant for involvement over the course of the funding period to: • Participate on the identified project team • Develop 4 presentations for the System of Care • Strengthen relationships with medical providers to increase attendance at SOC and overall collaboration and coordination of care with ICC-enrolled members. • Assist in identification of care extender application for ICC-enrolled members

6. Existing Internal Resources – Project 1. Integration, Coordination & Consultation:

The Project team will leverage our affiliation with Lahey Health and our current embedded integrated clinicians to strengthen relationships with medical providers. We will also draw from the lessons learned from other Integrated Care Management Services such as Here For You and CHART. As noted previously, the current System of Care meeting is a context by which we will further our integration goals for a larger community impact. Members of the Senior Leadership Team and Medical Directors will also be consulted and offer insights to addressing barriers or challenges. We will also leverage our current consulting psychiatrists for each CSA. Integration efforts will live on after the phase out of the DSRIP funded Medical Consultant with these current medical members of LHBS.

7. Distribution of Funds – Project 1. Integration, Coordination & Consultation	
$97,600 proposed funds used for Medical consultant	Average number of ICC-engaged members

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1. Project 2 Name: Trauma Informed Care Model Training	
2. Project Goal & Plan to Meet Goals	
Workforce Development through Training and Certification of CSA Staff	Training/Certification of a TIC Model, "Risking Connections"

3. Project Scope, Method and Activities:

Many of our families identify through the assessment period needs relating to trauma or the experience of chronic stress. Through previous and current integration efforts, LHBS understands how complex stress and trauma impact the whole person including the evident impact on diagnoses such as asthma, obesity and diabetes and other medical conditions. LHBS will adopt a sustainable TIC model that will be meaningful to all CSA staff from those who answer the phones and accept referrals to our on call ICC staff supporting families with urgent care needs. This will ensure a consistent approach to families across roles and teams that will provide the lens in which ICCs and Family Partners see behavior and impacts of trauma. If successful over the course of DSRIP funding, LHBS will consider expanding this model organization wide independent of DSRIP funds.
The proposed model, "Risking Connections", is aimed at mental health, public health, and substance

use workforces. This model was identified due to its focus on concepts of empowerment, connection and collaboration. This model is appropriate for ICC use due to its fostering of "RICH" relationships (acronym for Respect, Information Sharing, Connection and Hope) which resonates with the Wraparound principals.

The use of this model aims to improve the overall experience for members due to CSA staff's deeper understanding of trauma and how trauma re-enactment can impact the wraparound process. With this knowledge care plan teams will have improved interactions amongst members. Understanding of trauma re-enactment supports a team's safety planning process thus reducing moments of crisis for families. This project also aims to ensure families and CSA staff recognizes the connection between adverse experiences and chronic medical conditions. With a deeper knowledge of a common underlying need through an evidenced based model, LHBS is positioned to improve overall sustainability of care plans and therefor outcomes for youth and families served. Please see below for a list of activities:

Budget Period	Use of Funds received	Methods/Activities
Prep	3 day training scheduled Consultation with "Risking Connections"	• Project team to consult with "Risking Connections" training team to schedule 3 day training for both CSA's. Ensure training team is aware of integration efforts • Identification of at least one "train the trainer" to ensure sustainability of the model • CSA workforce to attend 3 day training to achieve certification in the mode
Year 1	Efforts to sustain training internally	• Ongoing consultation and support by Risking Connecting Training Team to ensure sustainability of the model • Annual training webinar for Train the Trainer(s) (ongoing task) • Train the Trainer to conduct training for CSA new hires (ongoing task)
Year 2	"Risking Connections" Efforts to sustain training internally	• Final formal consultation with "Risking Connections" Training team to ensure sustainability of the model • Biannual full day training for the Train the Trainer(s) to maintain certification (ongoing task) • Annual Webinar for Train the Trainer (ongoing task) • Train the Trainer to conduct training for any new hires (ongoing task)
Year 3	"Risking Connections"	• Ongoing tasks
Year 4	"Risking Connections"	• Ongoing tasks • Assess any needs relating to sustainability

Year 5	"Risking Connections"	• Ongoing tasks • Project team to include Train the Trainer expenses in next fiscal year budget.

4. Deliverables- Project 2 Trauma Informed Care Model Training

- Certification in Trauma Informed Care for all CSA staff
- At least 1 LHBS employee to achieve a "train the trainer" certification status for the Trauma informed Care Model.
- Retention of highly skilled CSA workforce
- Reduction of burnout or vicarious trauma

5. Use of DSRP Funding- Project 2 Trauma Informed Care Model Training

$58,625	Trauma Informed Care Model and workforce costs while participating in the 3full day training sessions.

6. Existing Internal Resources:

LHBS has an established and robust HR Department that will be leveraged to focus on retention strategies to reduce training needs related to turnover. Some of these current strategies include the use of a "Collectivist Culture" to reduce isolation, depression and frustration, and remunerative benefits including competitive salaries and benefits including tuition assistance and other incentives. Moreover, LHBS intends to leverage our current training and orientation programs. Current internal resources include our capacity to send CSA workforce to Tier 1 Wraparound certification. We will continue these efforts without the use of DSRIP dollars to ensure high fidelity Wraparound for the best outcomes for our ICC-engaged members. We will use current HR and training systems to roll out training plans in a way that feels supportive to staff and allow the project team to monitor training efforts and to hold CSA workforce accountable to achieving the training goals. Specifically, we will use our employee platform, PeopleSoft to track and monitor completion of trainings.

7. Distribution of Funds- Project 2 Trauma Informed Care Model Training

$58,625 for "Risking Connections" trauma informed care training	Total number of staff *12,000 dedicated to fund Haverhill Staff time while participating in the 3-day training

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1. Project 3 Name: Technological Updates and Smartphone Connectivity

2. Project Goal & Plan to Meet Goals

Improve Technology Infrastructure.	Improve communication amongst care plan team members, ACOs and PCPs through secure messaging, increased ICC mobile connectivity and potential for remote care plan participation. Strengthen connection to Mass HIway and other forms of secure communication and data sharing. Roll out of "Care Extender App" to workforce for pilot and to

	families at time of initial care plan if indicated.

3. Project Scope, Method and Activities:

LHBS has displayed a commitment to using technology to achieve state-of-the-art solutions to challenges of communication, coordination of services and to improve outcomes for our members across clinical settings. To achieve this goal, we will leverage our current experience and relationship with Lahey Health System and invest independently in additional software to perform core functions in our ICC program. Further supporting the vision of the DSRIP funding, LHBS is preparing to serve as a Behavioral Health Community Partner (BHCP) in the ACO model of care delivery. Currently, the CSAs are 1:1 laptop and smart phone communities to support care coordination and real-time communication amongst team members. This has improved operational efficiency as it enables our staff to mobilize a team during critical moments in care. The CSAs will use technology to enhance care coordination and the overall ICC-engaged member experience. This will be accomplished through updated hardware to ensure the CSAs are positioned to leverage our current G-SUITE applications for care planning purposes. Through investing in mobile connectivity, we aim to improve participation of care plan team meetings for urgent meetings that do not provide ample notice as well as increased opportunity of medical team member CPT participation. We will use projectors, screens in our conference rooms as well as tethering capability with smartphones to accomplish these tasks. We will leverage G-SUITE's Google meet to accomplish this.

The CSAs will adopt a "care extender" application that support interventions and efforts in overall health and wellness with its ICC-engaged members. This will be piloted with staff prior to rollout and then with ICC-engaged members. With the planned implementation of Netsmart Evolv ® across LHBS, we look forward to further leveraging all solutions to achieve fully automated interoperability requirements including connecting our industry standard tolls to the Mass HIway and other exchanges.

In this project, we will assess current technology and enhance hardware. This includes an inventory assessment of laptops and smartphones that are outdated and will prohibit the progress of projects included in this proposal. Other enhancements include the introduction of signature pads for added ease for the member for signing critical documents as well as tethering capability via ICC smart phones for remote access. This will allow for increased transparency for our ICC-engaged members with the capability to collaboratively document encounters with members.

Please see below for a list of activities by funding period:

Budget Period	Use of Funds received*	Methods/Activities
Prep	Upgrade hardware Signature pads Care extender apps Cell phone fees for remote connection Additional hardware to support remote care plan	• Engage IT department to assess technology needs and purchase laptops and signature pads • IT to train ICC staff start on tethering capability to pilot to ensure efficient use when present with ICC-engaged members • Roll out care extender app to CSA staff to gain familiarity • Initiate conversations with medical providers about methods for sharing clinical information

	participation	
Year 1	Care extender apps cell phone fees for remote connection	• Roll out use of signature pads • Engage IT department to troubleshoot any connectivity or hardware issues impacting staff use of software (ongoing) • Establish communication protocols with ACO's and care plan team members. Train CSA workforce • Roll out of care extender app to ICC-engaged members and their family (ongoing task)
Year 2	Care extender apps cell phone fees for remote connection	• Ongoing tasks • Work with HR to incorporate new technology enhancements into CSA New Hire orientation and onboarding
Year 3	Care extender apps cell phone fees for remote connection	• Ongoing tasks
Year 4	Care extender apps cell phone fees for remote connection	• Ongoing tasks • Project team to discuss plan for sustainability for cell phone fees for remote connection
Year 5	Care extender apps cell phone fees for remote connection	• Ongoing tasks • Project team to plan for incorporation of "care extender" application and cell phone fees into the next fiscal year budget.

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4. Deliverables- Project 3Technological Updates and Smartphone Connectivity

- Updating equipment and/or replacing irreparable equipment including rollout of signature pads and tethering capacity with smart phones.
- Adoption of "care extender" application in collaboration with other integrated care models within LHBS.
- Incorporate training needs related to "care extender" application and hardware improvements into CSA New Hire Orientation.

5. Use of DSRP Funding- Project 3Technological Updates and Smartphone Connectivity

$229,650	• Updating laptops and cell phones • Purchase signature pads • Purchase care extender apps for staff piloting and ICC-engaged member use on smart phones

	• Purchase projectors and screens to provide option of remote CPT participation

6. Existing Internal Resources- Project 3 Technological Updates and Smartphone Connectivity

This project would not be feasible without the investment made by LHBS to ensure1:1 laptop and smartphone communities at both CSA's as well as the current IT servers. With some updating of our most out of date or irreparable equipment, CSAs will be positioned to leverage our G-SUITE platform to allow for remote video conference participation of care plan team meetings through a simple google invite. LHBS currently runs the NetSmart Evolv ® EHR as part of its integrated care management HFY program and is in the final stages of planning to roll out the EHR to all service units in 2018. Evolv will serve as the comprehensive enrollee record and will be populated by clinical information and documentation of member information from all LHBS services and providers. Lastly, the agency has committed to maintaining smartphones for CSA workforce and will continue to replace phones that no longer meet the system requirements for remote connection and the care extender applications.

7. Distribution of Funds- Project 3 Technological Updates and Smartphone Connectivity	
$229,650 for hardware enhancements, care management software and care extender apps	-Laptop funds will be distributed based on needs -Other hardware enhancements will be distributed based on staffing totals -Care extender apps will be based on total number of ICC-engaged members.

1. Project 4 Name: Marketing to ACOs, PCPs, and Communities at Large	
2. Project Goal & Plan to Meet Goals	
Improve Operational Infrastructure by improving communication between ICC-engaged members and Medical providers.	Increase awareness of CSA and services provided to ACOs, and PCPs with specific marketing on how wraparound can address medical well-being. Marketing to communities at large

3. Project Scope, Method and Activities:

Lahey will use DSRIP funding to revamp current marketing material for the community at large and disseminate. During this time, ACO & PCP specific marketing will be created to increase awareness as well as identify ways in which the wraparound process can support medical needs.

LHBS has maintained a website for providers and the community to learn more about what is provided and how to contact/make referrals to service provided. DSRIP funding will be used to make updates to the CSA portions of the website including the ability to send inquiries directly to the program from the website.

Budget Period	Use of Funds received*	Methods/Activities

Prep	Communication Director Marketing Materials Web design	• Engage Communications Director and project team to develop a marketing plan for ACO's and PCPs • Create web redesign for CSA related pages • Purchase marketing materials • Roll out marketing plans and proposed web changes
Year 1	Communication Director Marketing Materials	• Regular meetings with Communications Director to maintain and adjust marketing plan as necessary • Purchase marketing materials as needed for dissemination.
Year 2/Year 3	Communication Director Marketing Materials	• Ongoing tasks
Year 4	Communication Director Marketing Materials	Ongoing tasks • Project team to discuss plan for sustainability current marketing strategies
Year 5	Communication Director Marketing Materials	• Ongoing tasks • Project team to plan for incorporation of marketing plans and materials into next fiscal year budget

4. Deliverables Project 4 Marketing to ACOs, PCPs, and Communities at Large

- Marketing strategy and yearly plans
- Marketing material ready for dissemination
- Changes in web design for CSA specific pages of the LHBS website.

5. Use of DSRP Funding- Project 4 Marketing to ACOs, PCPs, and Communities at Large

$81,997	• Marketing materials (including but not limited to fliers, pamphlets and postcares) • Updated web design for CSA specific pages of LHBS website.

6. Existing Internal Resources- Project 4 Marketing to ACOs, PCPs, and Communities at Large

LHBS will leverage current marketing material and efforts to make revisions and refinements with DSRIP funds. We will utilize our current Communications Department and website for this project.

7. Distribution of Funds- Project 4 Marketing to ACOs, PCPs, and Communities at Large

$15,866- Communication Department	Proposed funds will be used for operation staff of communication department as well as marketing material and

$66,064- Marketing material and web design	web design.
1. Project 5 Name: Workforce Retention & Recruitment	
2. Project Goal & Plan to Meet Goals	
Address vacant CSA positions in timely manner and create retention strategies to ensure timely access to care	Use recruitment efforts to fill vacant CSA positions Develop retention strategies to ensure CSAs retain their best and brightest staff.

3. Project Scope, Method and Activities:

LHBS will energize current recruitment activities with the use of DSRIP funds by identifying dedicated recruitment time and strategies specific for CSAs. This will entail close communication with the assigned project team and HR around hiring needs and criteria. In a similar light, a retention plan will be created with the project team and HR to pilot. Both of these activities will occur in year 1. Outcomes relate to extending the average length of employment of CSA staff whose current averages aligns with state averages of approximately 18 months of employment. Retention strategies will be determined through HR and CSA staff feedback and will include individual and site based incentives.

4. Deliverables Project 5 Workforce Retention & Recruitment

From this project, the CSAs will have a clear recruitment plan resulting in timely access to ICC. CSAs will also pilot a retention strategy to determine overall impact to increase the average length of employment from 18 months.

5. Use of DSRP Funding- Project 5 Workforce Retention & Recruitment

$35,500	• Retention activities • Recruitment activities

6. Existing Internal Resources- Project 5 Workforce Retention & Recruitment

LHBS Human resources department will be vital to the success of this project. We will leverage current hiring and retention strategies while looking for areas of improvement specific to the CSA's. This also includes using our current employee portal, PeopleSoft to collect data and disseminate information to CSA staff

7. Distribution of Funds- Project 5 Workforce Retention & Recruitment

$10,500 **$25,000**	• Recruitment expenses • Retention expenses

6. Existing Internal Resources – All Projects:

LHBS will maximize and leverage a variety of internal resources to ensure a smooth implementation of the identified projects. From a big picture lens, supporting all projects proposed for use of DSRIP funding LHBS will continue to rely upon internal structures. LHBS uses Advantage Healthcare Solutions as a billing vendor including coding support and revenue cycle management. We intend to work with this vendor to ensure data is available as needed. LHBS also has the ability to collaborate with Lahey Health System data analytics departments as needed to complete specific data requirements.

With regard to community engagement, LHBS will leverage its current business sites and services to identify potential ICC members and know how to connect these members to the CSAs. Funds allocated to marketing activities will target ACOs and PCPs to increase awareness of how the care planning can support maintenance of chronic medical diagnoses and overall awareness of services provided by the CSA.

For the overall success of the DSRIP projects, LHBS will leverage key staff for ongoing oversight and management including the Vice President of Ambulatory and CBHI Services, the Director of Operations for CBHI services, the Vice President of Information Technology and the Director of Communications. At the CSA program levels, the administrative coordinators will be responsible for data tracking of benchmarks and outcomes. CSA program directors will be pivotal in the implementation of projects as well.

Both Community Services Agencies have taken efforts to create program wide tracking to ensure timely completion of clinical documentation and to ensure that Care Plans are completed every 90 days at minimum. We will continue these efforts and leverage our EHR aplatform to further streamline this process.

8. Internal Evaluation, Measurement & Performance Evaluation – All projects

LHBS is committed to meeting all contract requirements related to quality management and performance monitoring by maintaining a strong Development Plan. A culture of quality is something that this organization takes pride in, where it is the focus of its workforce every day. Quality is not an, “add on”, to the job, but it is woven into the fabric of the whole organization. LHBS is committed to innovation and to continuous quality improvement at all levels of the organization and in all programs.

Each proposed project will have a dedicated Project Team. Each project team member will have assigned tasks outlined on a work plan. The project team along with the medical consultant will meet at minimum, on a monthly basis to assess progress towards activities and tasks within projects. For activities and tasks that are not met by identified timeframes, the team will determine barriers and revise the remaining project timelines to ensure future deadlines and benchmarks are met. The CBHI Operations Director will be responsible for oversight of the projects to ensure that efforts are coordinated among staff and not duplicated.

With the revised internal record review tool, we will assess our integration efforts on at least a quarterly basis through multidisciplinary reviews with the medical consultant and CSA leadership team. We will continue efforts to track paperwork completion with reporting capacities within our EHR to ensure that all ICC-engaged members have documented care plans that are approved by the

clinician and member and/or member's legal guardian. This data will be shared at regular project team meetings.

Training and certification will be monitored through training attendance taken by PD's and tracked in collaboration with HR. Effectiveness of the TIC model will be measured by pre and post trainings results of surveys that are chosen in collaboration with the Risking Connections training team. We will also measure this with retention rates over the 5 years of the project.

Within LHBS, we often turn to the people that we serve and their families as one of the most important metrics of quality. We will continue this important task by increasing the instances of completion of customer satisfaction surveys. Each quarter, the CSA's will strive to survey at least half of its current population served. These surveys will also assess the members overall satisfaction with the care management software and "care extender" applications. This will be facilitated by the program director and managers. The administrative coordinators will collect this data for review with the program director for submission to the project team.

6.4.B. PROJECT TEAM DESCRIPTION

For the proposed project(s), the Bidder shall describe its organization's level of readiness and proposed Project Team for implementing the proposed project(s), including:

(1) An organizational chart of the Bidder (as an attachment) that identifies personnel, senior managers, and other staff by title (not counted toward page limit);

Please see attachment 6.4.B.1 for an overview of LHBS from executive leadership highlighting internal resources we will leverage, to senior leadership and program level organization of the Community Service Agencies.

(2) A list of current staff that the Bidder proposes will be involved in the project(s), including their job descriptions and qualifications for the project(s);

The table below shows the identified project team members including their qualification and job descriptions for the project

Name/ Title	Qualifications	Project Team responsibilities
Catherine Pietrzak ***Vice President of Ambulatory and CBHI Services***	• MBA • 20 years of behavioral health management • Experience with project management • Led Outpatient Clinics through transition to open access	Provide updates to senior leadership team, quarterly data review; support implementation process and team as needed; working to help identify barriers and/or successes.
Sangita Mallick, M.D. ***Child Psychiatrist*** ***Current consultant to CSA;s***	• Current consultant to CSAs with awareness of trends presenting in the community in terms of behavioral health need • Experienced psychiatrist working in various settings: inpatient,	Content expert for psychiatric needs, including assessment of medication referral/recommendations - including weekly coordination with the Project team, offering recommendations on tools, measures and best practice

	community health center, outpatient, emergency services and CBHI	
Jessica Caron, LICSW ***Director of Operations- CHBI Services***	• Strong knowledge of all CBHI services including CSAs. • 10 years of experience working with youth & families and CBHI • Former ICC	Oversight of project, including data collection review and achieving benchmarks; supporting the directors as needed in quality assurance, clinical decision making. Direct coordination with MD and other training oversight
Brad Eardley, LMFT ***Director- Cape Ann/Beverly CSA*** **Colleen McKenna, LMHC** ***Director- Haverhill CSA***	• Strong knowledge of all CBHI services including CSAs. • Passion and strong experience in working with youth and families including program management • Program level insight	Coordinating enhancement and changes; holding staff accountable to attendance at trainings, ensuring integration efforts are followed through at the direct care level; identifying areas of need and successful - creating action plans to ensure benchmarks are achieved
Donna Lemelin ***Administrative Coordinator- Cape Ann/Beverly CSA*** **Alyssa Landry** ***Administrative Coordinator- Haverhill***	• 10 years of combined administrative support to the CSA's • Program level insight	Data input and collection; reporting as needed; other administrative functions as needed.

(3) Any staff the Bidder proposes to hire or engage to be involved in the project(s), including their proposed job descriptions and qualifications for the project(s);

TBA ***Medical Consultant***	• **MD or RN** • **Experience in pediatric field of medicine and integration** • **Passion for work with youth and families**	• **Review and identify areas for opportunity in integrating medical components of care.** • **Provide clinical leadership in integration for project team** • **Analyze and utilize data for quality improvement** • **Design and participate in medical curriculum**

(4) The roles and responsibilities of each staff of the Bidder's Project Team and how the Bidder will ensure efforts are coordinated among staff and not duplicated; and

Please see the table above for a list of responsibilities for each staff of the Project Team. Efforts will be coordinated by monthly meetings of the project team to assess progress towards assigned tasks and goals.

(5) A description of how the Bidder proposes to manage the project(s).

The Operations Director will be responsible for oversight of the project to ensure that efforts are coordinated among staff and not duplicated. Each project team member will have assigned tasks on a work plan that will be reviewed monthly. Barriers to completion of tasks will be addressed and timelines adjusted to ensure future benchmarks are met.

Note: Job descriptions may be submitted as attachments and will not count toward the page limit.

6.4.C. IMPLEMENTATION PLAN AND TIMELINE

For the proposed project(s), the Bidder shall submit one timeline that displays the Bidder's monthly implementation plans, including a timeline for the Preparation Budget Period, and quarterly implementation plans for each subsequent Budget Period. The timeline shall include all necessary operational and project activities to accomplish the project(s).

The implementation Plan provided on the following pages is structured to reflect the three projects and uses a Gantt view to display activities by month for the preparation budget period and by quarter for subsequent budget periods. This plan will be expanded to include additional details in the fall as implementation activities begin.

6.4.D. BUDGET REPORT AND BUDGET NARRATIVE

The Bidder shall submit one Budget Report and one Budget Narrative, using Attachments B and C, to estimate the amount and types of costs associated with implementing the Bidder's proposed project(s).

6.4.E. SUSTAINABILITY

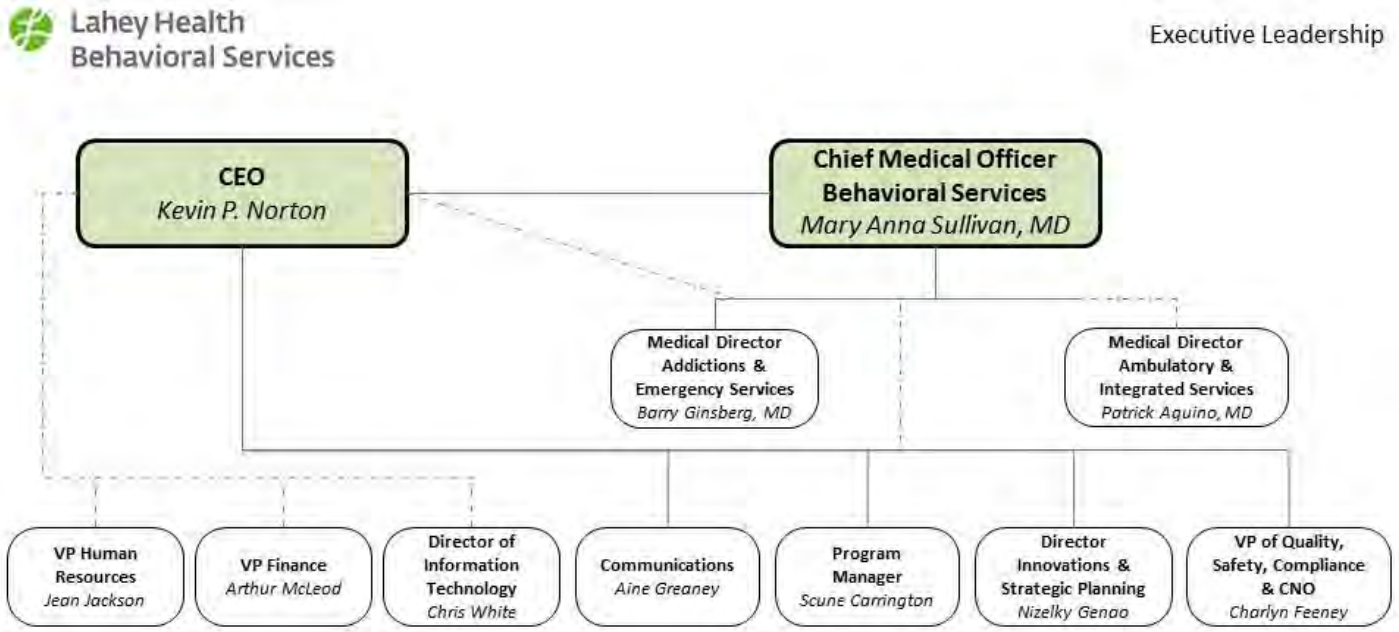
The Bidder shall describe its plan to sustainably fund the proposed project(s) over the Contract term and after the end of the Contract term. Such description shall include a description of any tools, resources, or processes the Bidder intends to develop as part of the project or investment funded under the Contract that the Bidder would continue to use after the end of the Contract term.

As indicated in section 6.4.A.3 Sustainability was at the forefront in the planning of identified projects to ensure that all DSRIP funded efforts continue after the funding life cycle. Steps are noted in the implementation plan to ensure sustainability. Specifically, tools created and revised by the medical consultant and project team will continued be used, and adherence will be monitored through quality assurance such as record reviews. The relationships strengthened and/or built with PCP offices and ACOs will continue through ongoing bi-directional communication, involvement in the Systems of Care and regularly scheduled meetings that will occur in collaboration with the BHCP.

By leveraging our current IT infrastructure, LHBS will continue to fund software to sustain efforts relating to collaboration and information sharing. LHBS intentionally chose a TIC model with a train-the-trainer option to allow for sustainability using the model at cost the agency can sustain and will leverage current resources such as the Director of Training, our HR department and Peoplesoft to sustain training and workforce investment efforts

Attachment 6.4.B.1 Organizational Charts

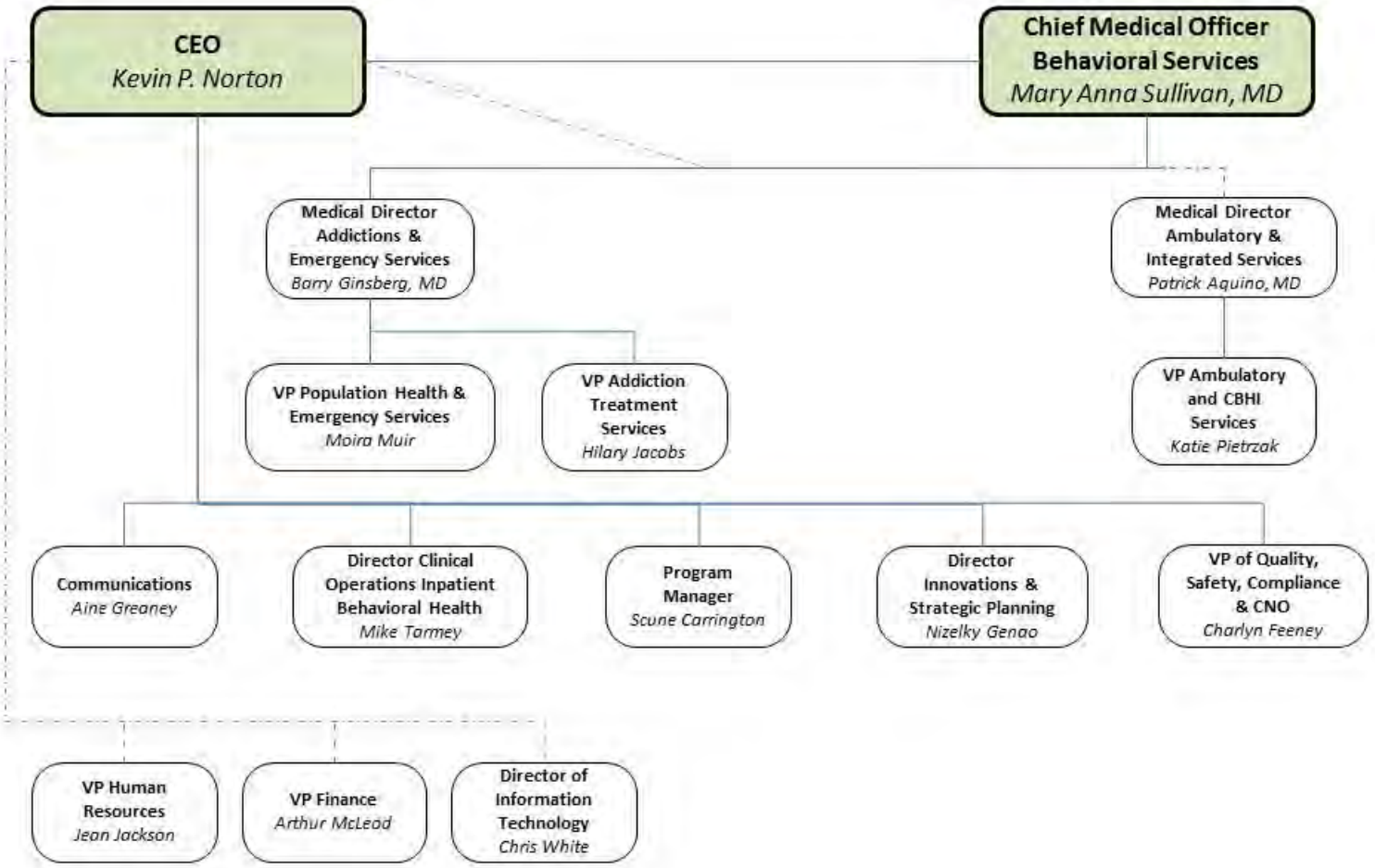
Attachment 6.4.B.1.a

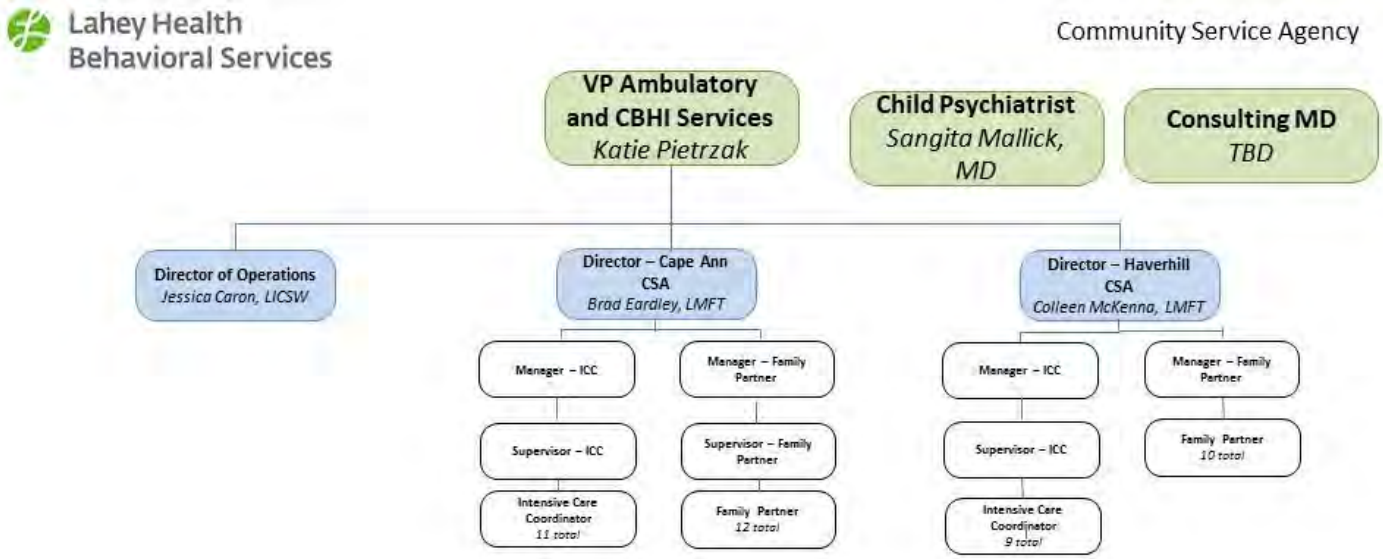


Attachment 6.4.B.1.b

Lahey Health Behavioral Services

Senior Leadership





E/21/2017

Attachment 6.4.B.1.c

Attachment 6.4.B.2 Job Descriptions

Lahey Health
Behavioral Services

JOB DESCRIPTION

Job Title: VP of Ambulatory and CBHI	Approval Date: Click here to enter text.
Division: Ambulatory	Dept./Program/Location: General & Administrative
Reports to: Medical Director	FLSA Status: ☒Exempt ☐Non-Exempt

POSITION SUMMARY:

In 3-5 sentences, summarize the purpose of this job. Your text should answer the question: "Why does this position exist?" The position purpose and level in the organization should be concisely stated here.

The Vice President of Ambulatory and CBHI oversees and manages the programs within this division, maintaining the quality of treatment, assuring compliance with programmatic regulatory and licensing requirements, maintaining staffing and productivity levels, ensuring customer satisfaction and cost effective service delivery, implementing continuous quality improvement initiatives, and developing and ensuring compliance with managed care contracts, State Contracts. The VP participates in and serves as a conduit for information and direction from the Senior Leadership Team of the organization, ensuring consistency of operational oversight in keeping with the organization's mission.

ESSENTIAL FUNCTIONS & RESPONSIBILITIES:

In this section, please clarify the tasks and deliverables of each essential function and responsibility of this job. Please provide in a list formant with bullets and identify the 5-7 responsibilities/functions of this job in order of importance.

Essential Functions/Key Responsibilities:

1. Program leadership and development, including oversight of clinical integrity and sustainability of the programs within the division.

2. Budget development and monitoring including revenue and expense tracking and adjustment.

3. Provide leadership to a multidisciplinary team, building cohesiveness within programs and between programs located in multiple physical locations through regular staff meetings and visitations to programs.

4. Ensure ongoing quality improvement including outcome measurement, quality management activities, satisfaction surveys, and quality record reviews.

5. Build programs and respond to needed changes in existing services based on key stakeholder feedback.

6. Develop, update/revise policies and procedures as needed.

7. Participate in the Senior Leadership Team; assist in strategic decision making and planning to help the organization to meet its mission and needs of population served.

8. Collaborate with leadership and staff from other Divisions and programs within the organization to assist in integration and efforts to provide seamless, coordinated care for populations served.

9. Develop and maintain positive, ongoing relationships with key stakeholders; including, but not limited

Job Description

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Lahey Health
Behavioral Services

JOB DESCRIPTION

Job Title: Staff Psychiatrist	Approval Date: Click here to enter text.
Division: Ambulatory & CBHI	Dept./Program/Location: General & Administrative
Reports to: Medical Director	FLSA Status: ☒Exempt ☐Non-Exempt

POSITION SUMMARY:

In 3-5 sentences, summarize the purpose of this job. Your text should answer the question: "Why does this position exist?" The position purpose and level in the organization should be concisely stated here.

The staff psychiatrist is responsible for providing medical evaluation, ongoing psychiatric assessments and treatments, prescriptive services, urgent care appointments, ordering and review of laps and tests and may provide some off hour on call coverage. The Staff psychiatrist also acts as a consultant to CBHI services

ESSENTIAL FUNCTIONS & RESPONSIBILITIES:

In this section, please clarify the tasks and deliverables of each essential function and responsibility of this job. Please provide in a list formant with bullets and identify the 5-7 responsibilities/functions of this job in order of importance.

Essential Functions/Key Responsibilities:

1. Psychiatric Evaluation, direct diagnostic, prevention and treatment services to children, adolescent and their families

2. Ongoing psychiatric service and staff consultation to Outpatient and CBHI services.

3. Provide leadership to a multidisciplinary team, building cohesiveness within programs and between programs located in multiple physical locations through regular monthly meetings.

4. Treat children, adolescents and adults within the context of recognizable and sound medical standards.

6. Develop, update/revise policies and procedures as needed.

7. Provide training to staff

8. Collaborate with leadership and staff from other Divisions and programs within the organization to assist in integration and efforts to provide seamless, coordinated care for populations served.

9. Develop and maintain positive, ongoing relationships with key stakeholders; including, but not limited to, Department of Children and Families, Department of Mental Health, Massachusetts Behavioral Health Partnership, local schools, community groups, and funders and represent organization on community and trade association committees as requested.

10. Provide emergency and crisis intervention services

11. Participate in monthly multidisciplinary meetings.

Job Description

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Lahey Health
Behavioral Services

JOB DESCRIPTION

Job Title: Operations Director - CBHI	Approval Date: March 17,2017
Division: Ambulatory	Dept./Program/Location: Ambulatory Division
Reports to: VP of Ambulatory Division	

POSITION SUMMARY:

In 3-5 sentences, summarize the purpose of this job. Your text should answer the question: "Why does this position exist?" The position purpose and level in the organization should be concisely stated here.

Responsible for overseeing the operations of the residential and community-based programs for children and youth. Under general supervision of the VP of Ambulatory Services, works within general methods and procedures and exercises considerable independent judgment to adapt and apply the guidelines to specific situations as needed. The work requires knowledge of the policies, procedures, and regulations of community based programs, and supervisory techniques, personnel policies, and procedures. This individual will be responsible for ensuring and monitoring all tracking systems to meet all regulatory and funder guidelines.

ESSENTIAL FUNCTIONS & RESPONSIBILITIES:

Essential Functions/Key Responsibilities:

1) Assess administrative and management needs of the CBHI and youth services ; develop, implement, evaluate and manage all clinical and non-clinical program elements, provide consultation, administrative support and resource development and allocation.
2) Review current tracking systems and determine most effective ways to streamline and to meet regulatory mandates MCEs performance specs for CBHI programs.
3) Create and/or maintain all necessary training and tracking systems.
4) Set up, monitor and maintain master tracking system to ensure that all staff remains up to date on trainings required by EEC, BSAS and DOE for all programs licensed by these entities within the Division.
4) Working with PD's and Office Managers to motivate, assist, and evaluate administrative support and clerical personnel, including performance challenges. Implement discipline and/or utilize termination procedures as necessary.
8) Assist VP of Ambulatory Services in establishing policies and procedures, including participation in budget preparation, monitoring contracts and productivity.
10) Maintain confidentiality regarding privileged administrative and child/youth information in a professional manner.
11) Provide trainings to staff as needed around operations related issues
12) Work collaboratively with facilities and IT to ensure the daily operations of the programs run as smooth as possible.
14) Work with Division VP to create or revise current policies and procedures as needed
15) Other duties as assigned.

Leadership positions should describe the type and level of supervision exercised over specific job titles.

Job Description

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Behavioral Services

JOB DESCRIPTION

Job Title: Director	Approval Date: April 3,2017
Division: CBHI	Dept./Program/Location: Various CBHI Programs
Reports to: VP of Ambulatory Services	

POSITION SUMMARY:

In 3-5 sentences, summarize the purpose of this job. Your text should answer the question: "Why does this position exist?" The position purpose and level in the organization should be concisely stated here.

The Program Director will oversee the adequacy, appropriateness, fiscal viability, and quality of clinical and operational programming as well as implement orientation, supervision, and staff performance activities to ensure high standards of client and organization results. He/she will also monitor workers' productivity, implement multidisciplinary team meetings, high risk case reviews, supervision and staff evaluations. Develops and introduces approved standards and guidelines for CBHI programs.

ESSENTIAL FUNCTIONS & RESPONSIBILITIES:

In this section, please clarify the tasks and deliverables of each essential function and responsibility of this job. Please provide in a list formant with bullets and identify the 5-7 responsibilities/functions of this job in order of importance.

Essential Functions/Key Responsibilities:

1. Develops, implements, monitors and reviews operating budget. Ensures that internal reports are produced and reviewed in a timely fashion.

2. Ensures that clinical supervision is received by all clinical staff appropriate to individual's level of education and expertise, either via phone or in person.

3. Responsible for the oversight of clinical programming and continuously evaluates the effectiveness of the programming, making recommendations and changes when needed.

4. Maintain statistics on the activities of the program, recommend strategies for improvement in performance, productivity, and profitability. Continuous quality improvement for CBHI services through development of procedures, manuals, training materials, participation in trainings, best practices, using staff and the research literature as resources.

5. In collaboration with the VP of Ambulatory Services ensure adherence to quality assurance policies and procedures. Assist in assurance of site compliance with regulatory and other accreditation agencies.

6. Build and maintain effective working relationships with internal, external providers, as well as other regulatory bodies.

7. Serve as a key liaison for the program and direct the resolution of inquiries, problems, complaints, or emergencies affecting availability or quality of services; respond to sensitive or complex inquiries, service complaints, or grievances filed.

Job Description

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Lahey Health
Behavioral Services

JOB DESCRIPTION

Job Title: Administrative Coordinator	Approval Date: Click here to enter text.
Division: CBHI	Dept./Program/Location: Various CBHI Programs
Reports to: Program Director	FLSA Status: ☒Exempt ☐Non-Exempt

POSITION SUMMARY:

In 3-5 sentences, summarize the purpose of this job. Your text should answer the question: "Why does this position exist?" The position purpose and level in the organization should be concisely stated here.

The Administrative Coordinator will contribute to the smooth operation of the program(s) by performing, coordinating and overseeing administrative functions and projects within a program or group of programs within the Children's Behavioral Health Services division.

ESSENTIAL FUNCTIONS & RESPONSIBILITIES:

In this section, please clarify the tasks and deliverables of each essential function and responsibility of this job. Please provide in a list formant with bullets and identify the 5-7 responsibilities/functions of this job in order of importance.

Essential Functions/Key Responsibilities:

1. Oversees and ensures that the office administrative functions assigned are effectively carried out.

2. Provides professional assistance to management staff with the implementation of changes within the program/division to enhance the admission process and overall client experience

3. Performs difficult, complex, technical, and/or specialized office support work, which requires independent judgment, the application of technical skills, and a detailed knowledge of the activities and procedures specific to the program/division assigned.

4. Supervises staff, including determining workloads and schedules, evaluating staff performance, providing training and making hiring, promotion and disciplinary recommendations.

5. Provides technical assistance to program staff on operational issues such as personnel policies, payroll, travel expense, check request, purchasing, record keeping and training.

6. Tracks and maintains prior and upcoming authorization for services by communicating with insurance companies and service providers. Coordinates with staff to support and remedy any eligibility issues when necessary.

7. Interfaces with families of whom we receive referrals and provides frequent updates with families regarding wait times, etc.

8. Orientates new employees to program including but not limited to safety procedures, IT needs, voicemail, office space assignment, access codes, etc.

Job Description

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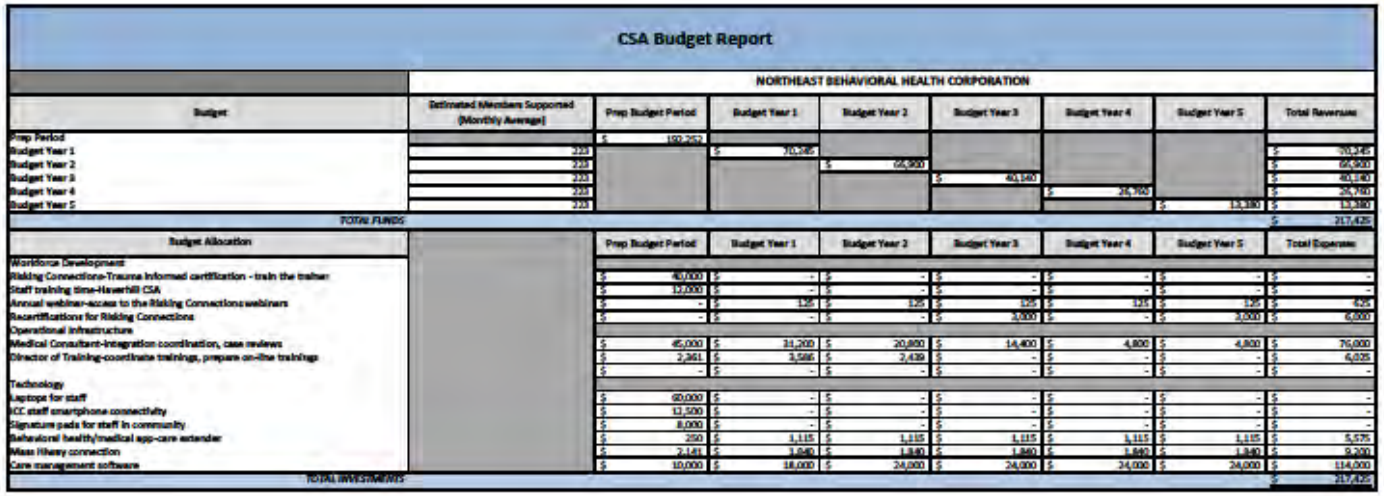
Budget Allocation Worksheet

	NORTHEAST BEHAVIORAL HEALTH CORPORATION							
Budget	**Estimated Members Supported (Monthly Average)**	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Revenues**
Prep Period		$ 192,252						
Budget Year 1	223		$ 70,245					$ 70,245
Budget Year 2	223			$ 66,900				$ 66,900
Budget Year 3	223				$ 40,140			$ 40,140
Budget Year 4	223					$ 26,760		$ 26,760
Budget Year 5	223						$ 13,380	$ 13,380
TOTAL FUNDS								$ 217,425

Budget Allocation	**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Workforce Development							
Integration	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training & certification of CSA staff	$ 52,000	$ 125	$ 125	$ 3,125	$ 125	$ 3,125	$ 6,625
Care Management software and hardware improvement	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Integration	$ 45,000	$ 31,200	$ 20,800	$ 14,400	$ 4,800	$ 4,800	$ 76,000
Training & certification of CSA staff	$ 2,361	$ 3,586	$ 2,439	$ -	$ -	$ -	$ 6,025
Care Management software and hardware improvement	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology							
Integration	$ 2,141	$ 1,840	$ 1,840	$ 1,840	$ 1,840	$ 1,840	$ 9,200
Training & certification of CSA staff	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Care Management software and hardware improvement	$ 90,750	$ 19,115	$ 25,115	$ 25,115	$ 25,115	$ 25,115	$ 119,575
TOTAL INVESTMENTS							$ 217,425

Attachment B: CSA Budget Report Template



CSA Budget Report

NORTHEAST BEHAVIORAL HEALTH CORPORATION

Budget	Estimated Members Supported (Monthly Average)	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Prep Period		$ 192,252						
Budget Year 1	223		$ 70,245					$ 70,245
Budget Year 2	223			$ 66,900				$ 66,900
Budget Year 3	223				$ 40,140			$ 40,140
Budget Year 4	223					$ 26,760		$ 26,760
Budget Year 5	223						$ 13,380	$ 13,380
TOTAL FUNDS								$ 217,425

Budget Allocation	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Workforce Development							
Risking Connections-Trauma informed certification - train the trainer	$ 40,000	$ -	$ -	$ -	$ -	$ -	$ -
Staff training time-Haverhill CSA	$ 12,000	$ -	$ -	$ -	$ -	$ -	$ -
Annual webinar-access to the Risking Connections webinars	$ -	$ 125	$ 125	$ 125	$ 125	$ 125	$ 625
Recertifications for Risking Connections	$ -	$ -	$ -	$ 3,000	$ -	$ 3,000	$ 6,000
Operational Infrastructure							
Medical Consultant-integration coordination, case reviews	$ 45,000	$ 31,200	$ 20,800	$ 14,400	$ 4,800	$ 4,800	$ 70,000
Director of Training-coordinate trainings, prepare on-the trainings	$ 2,361	$ 1,586	$ 2,439	$ -	$ -	$ -	$ 6,025
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology							
Laptops for staff	$ 60,000	$ -	$ -	$ -	$ -	$ -	$ -
FCC staff smartphone connectivity	$ 12,500	$ -	$ -	$ -	$ -	$ -	$ -
Signature pads for staff in community	$ 8,000	$ -	$ -	$ -	$ -	$ -	$ -
Behavioral health/medical app-care extender	$ 250	$ 1,115	$ 1,115	$ 1,115	$ 1,115	$ 1,115	$ 5,575
Mass Hiway connection	$ 2,141	$ 1,840	$ 1,840	$ 1,840	$ 1,840	$ 1,840	$ 9,200
Care management software	$ 10,000	$ 18,000	$ 24,000	$ 24,000	$ 24,000	$ 24,000	$ 114,000
TOTAL INVESTMENTS							$ 217,425

Attachment C: CSA Budget Narrative

Budget Expenses:

(Investment narrative should only include investments listed in the Budget Report provided on Attachment B. Please provide separate descriptions of budget allocations for each project)

Workforce Development **Total:** $58,625

In the box below, please provide a description of all items within the Workforce Development investment category (e.g. recruitment support, training and coaching programs and certifications). Please be sure to specify the goals and project(s) this investment will support, as described in **Section 3.4** and **Section 6** of the RFR and how these investments will assist in meeting the terms of the Contract.

Prep Budget Workforce Development Investments:

Using the train-the-trainer model, LHBS will engage Risking Connections to provide trauma-informed instruction and certification at a cost of $40,000.
Using an average hourly rate for the staff of $20.00 per hour plus a 25% fringe benefit factor, it is estimated that the cost for Haverhill CSA staff to attend the training to be $25.00 per hour x 20 employees x 24 hours of training = $12,000. This training supports providing ICC using dedicated care coordinators trained in Wraparound principles and practices.

Year 1 Budget Workforce Development Investments:

Annual webinar will provide access to the Risking Connections webinars for all staff at a cost of $125. The webinar training supports providing ICC using dedicated care coordinators trained in Wraparound principles and practices.

Years 2-5 Budget Workforce Development Investments:

Year 2 Annual webinar will provide access to the Risking Connections webinars for all staff at a cost of $125. The webinar training supports providing ICC using dedicated care coordinators trained in Wraparound principles and practices.
Year 3 Annual webinar will provide access to the Risking Connections webinars for all staff at a cost of $125. Year 3 Recertification for Risking Connections is an on-site training that provides additional train-the-trainer training and renewal of prior certification at a cost of $3,000. The webinar training and recertification supports providing ICC using dedicated care coordinators trained in Wraparound principles and practices.
Year 4 Annual webinar will provide access to the Risking Connections webinars for all staff at a cost of $125. The webinar training supports providing ICC using dedicated care coordinators trained in Wraparound principles and practices.
Year 5 Annual webinar will provide access to the Risking Connections webinars for all staff at a cost of $125. Year 5 Recertification for Risking Connections is an on-site training that provides additional train-the-trainer training and renewal of prior certification at a cost of $3,000. The webinar training and recertification supports providing ICC using dedicated care coordinators trained in Wraparound principles and practices.

Operational Infrastructure **Total:** $129,386

In the box below, please provide a description of all items within the Operational Infrastructure investment category (e.g. system change resources, performance management capabilities and additional operational support). Please be sure to specify the goals and project(s) this investment will support, as described in **Section 3.4** and **Section 6** of the RFR and document how these investments will assist in meeting the terms of the contract.

Prep Budget-Operational Infrastructure Investments:

The medical consultant is estimated at 225 hours at a rate of $200.00 per hour to review, revise and define clinical

quality measures, to review processes and to train ICC and Family Support and Training staff on integration with medical providers providing infrastructure support for ICC and Family Support and Training services at a cost of $45,000.
Director of Training is estimated at 2 hours per week for 20 weeks at a rate of $36.06 plus 25% for fringe benefits at a total cost of $45.07 x 52.38 hours = $2,361 providing infrastructure support for ICC and Family Support and Training services.

Year 1 Budget-Operational Infrastructure Investments:

The medical consultant is estimated at 4 hours per week at a rate of $200.00 per hour ($200.00 x 4 hours x 39 weeks) at a total cost of $31,200.
Director of Training is estimated at $36.78 plus 25% for fringe benefits at a total cost of $45.97 x 2 hours per week x 39 weeks = $3,586.

Years 2-5 Budget-Operational Infrastructure Investments:

Year 2 Medical consultant is estimated at 2 hours per week at a rate of $200.00 per hour ($200.00 x 2 hours x 52 weeks) at a total cost of $20,800.
Year 2 Director of Training is estimated at $37.51 plus 25% for fringe benefits at a total cost of $46.89 x 1 hour per week x 52 weeks = $2,439.
Year 3 Medical consultant is estimated at 6 hours per month at a rate of $200.00 per hour ($200.00 x 6 hours x 12 months) at a total cost of $14,400.
Year 4 Medical consultant is estimated at 4 hours per month at a rate of $200.00 per hour ($200.00 x 4 hours x 12 months) at a total cost of $4,800.
Year 5 Medical consultant is estimated at 4 hours per month at a rate of $200.00 per hour ($200.00 x 4 hours x 12 months) at a total cost of $4,800.

Technology **Total:** $221,666

In the box below, please provide a description of all line items within the Technology investment category (e.g. Health Information Technology and care management software, IT project management resources, data analytics capabilities, ICC service delivery technology). Please specify the goals and project(s) this investment will support, as described in Section 3.4 and Section 6 of the RFR and explain how these investments will support the Contractor's performance of the Contract.

Prep Budget-Technology Investments:

Laptops for staff will allow more community linkages since the workforce will be mobile. Cost for 50 laptops is $1,200 each for a total cost of $60,000.
ICC staff smartphone connectivity provides mobile access to workfiles and supports greater community linkages. Cost for 25 ICC staff is $100 per month x 25 devices x 5 months = $12,500.
Signature pads for staff in the community allows consent agreements to be signed immediately by family members/guardians and supports faster access to services at a cost of $200 per device x 40 devices = $8,000.
Behavioral health/medical application care extender for 50 staff at a cost of $5 per app download/instance at a total cost of $250 allows staff to become familiar with a tool to enable clients to use technology to assist in care management.
Connection to MA HIway integrates care among medical and other service providers to better manage client care at a cost of $2,141.
Care management software supports the goal of supporting referrals to other behavioral health resources and services by interfacing directly with other providers at an estimated cost of $2,000 per month x 5 months = $10,000.

Year 1 Budget-Technology Investments:

Behavioral health/medical application care extender for 223 clients at a cost of $5 per app download/instance at a total cost of $1,115 enables clients to use technology to assist in care management.
Connection to MA HIway integrates care among medical and other service providers to better manage client care at a cost of $1,840.
Care management software supports the goal of supporting referrals to other behavioral health resources and services

by interfacing directly with other providers at an estimated cost of $2,000 per month x 9 months = $18,000.

Years 2-5 Budget-Technology Investments:

Year 2 Behavioral health/medical application care extender for 223 clients at a cost of $5 per app download/instance at a total cost of $1,115 enables clients to use technology to assist in care management.
Year 2 Connection to MA HIway integrates care among medical and other service providers to better manage client care at a cost of $1,840.
Year 2 Care management software supports the goal of supporting referrals to other behavioral health resources and services by interfacing directly with other providers at an estimated cost of $2,000 per month x 12 months= $24,000.
Year 3 Behavioral health/medical application care extender for 223 clients at a cost of $5 per app download/instance at a total cost of $1,115 enables clients to use technology to assist in care management.
Year 3 Connection to MA HIway integrates care among medical and other service providers to better manage client care at a cost of $1,840.
Year 3 Care management software supports the goal of supporting referrals to other behavioral health resources and services by interfacing directly with other providers at an estimated cost of $2,000 per month x 12 months = $24,000.
Year 4 Behavioral health/medical application care extender for 223 clients at a cost of $5 per app download/instance at a total cost of $1,115 enables clients to use technology to assist in care management.
Year 4 Connection to MA HIway integrates care among medical and other service providers to better manage client care at a cost of $1,840.
Year 4 Care management software supports the goal of supporting referrals to other behavioral health resources and services by interfacing directly with other providers at an estimated cost of $2,000 per month x 12 months = $24,000.
Year 5 Behavioral health/medical application care extender for 223 clients at a cost of $5 per app download/instance at a total cost of $1,115 enables clients to use technology to assist in care management.
Year 5 Connection to MA HIway integrates care among medical and other service providers to better manage client care at a cost of $1,840.
Year 5 Care management software supports the goal of supporting referrals to other behavioral health resources and services by interfacing directly with other providers at an estimated cost of $2,000 per month x 12 months = $24,000.

SECTION 6.5. COORDINATION WITH ACOS, MCOS, AND PRIMARY CARE PROVIDERS

(response not to exceed 3 pages)

The Bidder shall describe the Bidder's specific plans to improve collaboration and coordination with ACOs, MCOs, and primary care providers, particularly pediatric providers, in accordance with ICC performance specifications and in keeping with the goal of improving integration of behavioral and physical health care. In particular, the Bidder shall describe how it intends to improve:

6.5.A. BIDIRECTIONAL COMMUNICATION BETWEEN THE BIDDER AND PEDIATRIC PRACTICES;

We will continue to communicate our skills, expertise and value to ACO's, MCO's and PCP (most specifically pediatric practices), many of whom we have long standing relationships with. The LHBS Leadership Team, Program Directors, and marketing and communication experts will work collaboratively to increase and sustain awareness of our capacity to provide high-fidelity ICC services. We will ensure that we capitalize on other LHBS efforts to represent the ICC service to ICC eligible members during opportunities to inform them of our capacity, expertise and the role that behavioral health plays in that community's overall population.

For member specific bidirectional communication, we will continue current practices of sending welcome letters for enrolled ICC-members with the MCE Combined communication form as a way of providing education of the services we provide. LHBS is well positioned to improve upon our efforts related to integration. Some of these efforts include:

- Here For You (HFY) case management program. Members in the HFY program are, by definition, medically complex members who have high utilization of services. Our care managers intervene with members to provide care coordination services working closely with the member's PCP, specialty providers, BH clinicians and family members to ensure a cohesive and comprehensive treatment plan is in place. The success of this program in the first year has pushed LHBS to develop processes and protocols to communicate and engage with a variety of community-based PCPs, health systems and community providers that touch the members in order to coordinate care plans.
- ***CHART***: *(Community Hospital Acceleration, Revitalization & Transformation)* Over the past 3 years, LHBS has collaborated with community hospitals in the Lahey and Lowell General Hospital networks to provide care coordination services to members who frequently use the emergency departments. Defining frequent ED visits as a trigger for additional support, the CHART care managers work closely with the ED teams at these facilities including sharing clinical information and receiving automatic, electronic notifications when engaged members enter the ED.
- Integration with Primary Care. LHBS has demonstrated integration with Primary Care as LHBS has imbedded BH clinicians in 12 practices to collaborate with the PCP teams. In this context, the LHBS BH clinicians share a medical record with the PCP teams and participate in team discussions about high-risk members

We will expand on BHCP efforts for secure electronic communication including establishing interoperability of record systems. We will leverage the identified Health and Wellness tool to trigger more active and persistent communication with pediatric practices when medical needs arise. This will be monitored through quality assurance efforts.

During the funding period, LHBS will utilize the medical consultant to identify communication successes and gaps that can be addressed through proactive efforts. We will rely on our existing relationships with ACO's and pediatrician offices that located in the communities we serve including parent organization-Lahey Health, Lawrence General Hospital, Northshore Medical Center, Holy Family Hospital and Lowell General Hospitals.

6.5.B. REFERRAL MANAGEMENT PROTOCOLS FOR FOLLOW-UP AND INFORMATIONAL SHARING;

LHBS will continue referral management protocols in meeting the requirements for ICC-referred members. Through efforts to increase collaboration with ACO's, MCO's and primary care providers we will ensure that referral processes are clear and as streamlined as possible. We will enhance this by allowing for the receipt of referrals through secure messaging.

Through our experience of providing ICC, we understand that engagement and contact with our more vulnerable or complex members can be challenging. To increase engagement with these members, we will leverage our current process of using an online calendar to identify when our workforce has availability for intakes to offer to meet potential ICC-engaged members at their pediatricians' offices or ACO's to enroll in ICC. We will use signature pads to further streamline this process and ensure authorization is received at that time for information sharing.

6.5.C. TEAM-BASED TREATMENT PLANNING IN COLLABORATION WITH PEDIATRIC PRACTICES;

In conjunction with the MCE combined communication form and the identified health and wellness tool, LHBS will increase the inclusion of medical needs in care plans. This will be done through communication efforts that will include the invitation of the PCP to attend in person or via teleconference to care plan team meetings. If not medically indicated, or if in person/teleconference attendance is not possible ICC staff, with the training of the medical consultant, will ensure the PCP's identified strengths, needs, and brainstormed options and recommendations for the ICC-engaged member are noted in the meetings. We will leverage care management software for electronic care planning with teams and seek PCP approval of the care plan once finalized and approved by the ICC-engaged member and/or legal guardian.

LHBS will leverage current relationships; program level leadership and the medical consultant when barriers in collaboration present that are not resolved by the Care Plan Team.

6.5.D. TIMELY ACCESS TO ICC SERVICES; AND

LHBS will continue and enhance efforts to ensure timely access to ICC services. This requires a multifaceted approach including adequate staff, high fidelity wraparound, ongoing monitoring of medical necessity and identification of sustainable community resources that support seamless transitions from ICC level of care. LHBS recognize that seasonality plays a part in referral trends. With this data, we will work to better anticipate these seasons of increased and decreased referrals to ensure timely access.

Find and Retaining the Best and the Brightest: LHBS will continue close communication with HR and the Finance Department for creation of new positions when indicated by waitlist needs and recruitment strategies. Staff retention will be fostered through ongoing training efforts to ensure that ICCs feel confident in the skills required to serve youth and their families who meet the criteria for SED in high fidelity wraparound and trauma informed way. Further fostering retention the adoption of a TIC model strengthen prevention and early signs of vicarious trauma and burnout.

Medical Necessity: The CSAs have continued to emphasize the importance of providing service to the right members at the right time and with the right level of care. These continued efforts will support timely access to and transition from ICC level of care. Program directors and managers will

continue efforts to ensure that the ICC service is described accurately and that discharge is discussed at intake. This includes increasing our Family Support & Training capacity when care coordination needs have been met.

Sustainable Community Resources: The CSAs will continue efforts to ensure awareness of community resources to more quickly meet care coordination needs in sustainable ways. LHBS will ensure other programs with care coordination capacity are aware of their care coordination role, and ensure seamless transitions through on going education of the ICC service and their potential HUB role after a member transitions from ICC level of care. We will utilize our Systems of Care to continue to identify these resources and gaps in resources that the system can plan around.

6.5.E. CONNECTIONS TO SOCIAL SERVICES.

Through our experience of providing care coordination, the CSAs have observed how social determinants of health impact our members. We have and will continue to build strong collaborative relationships to expand our abilities to connect ICC-engaged members to appropriate social services to ensure that care plan teams are address the needs and strength of the ICC-engaged member in a holistic way.

These relationships will be fostered through our Systems of Care on a more macro level, and will be addressed on more mezzo and micro levels through meetings with program leadership. LHBS understands that these relationships are crucial to the overall well-being of ICC-engaged members and that unmet needs in any life domain have impacts on medical and behavioral health. An example of how we foster these relationships is the current efforts underway in our Haverhill CSA to develop stronger communication with DCF. In collaboration with the Area Director a collaborative plan was created to include:

- Cross training for both workforces
- Increased attendance at System of Care meetings by DCF
- LHBS attendance at a quarterly provide meeting at DCF
- Monthly standing office hours at DCF for ICC staff and managers to discuss any areas of concern for members

Through our Individual and Family Flexible Support Services contract we have improved communication with DMH through monthly meetings to discuss ICC-engaged youth who are “single service eligible”. We currently engage in secure messaging with DMH for improved communication and coordination of care.

Program leadership will continue and enhance efforts to ensure that the CSA workforce are aware of the available social services in the communities served including their role in an ICC-engaged members treatment and well-being and how to initiate involvement when indicated to ensure sustained improvement in member overall health and well-being. This will be accomplished through presentations and information in staff meetings and the inclusion of additional social service entities in our System of Care meetings including DTA and DDS.

CSA Budget Report

North Suffolk Mental Health Association, Inc.

Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites	1	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate	N/A	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)	60	60	140	150	160	160	
Estimated Funds	$ 79,440.00	$ 42,000	$ 58,800	$ 45,000	$ 42,240	$ 19,200	**$ 286,680**
At- Risk Withhold Rate			5%	10%	15%	20%	
Withhold			$ 2,940	$ 4,500	$ 6,336	$ 3,840	**$ 17,616**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 79,440.00	$ 42,000	$ 55,860	$ 40,500	$ 35,904	$ 15,360	**$ 269,064.00**

Investment Projects	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Project 1 Name: *WORKFORCE DEVELOPMENT PROJECT*							
DSRIP Goal(s) Addressed: Goal 1:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ 9,750	$ 7,000	$ 5,000	$ 2,500	$ 2,000	$ 1,000	$ 27,250
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 1 Total	$ 9,750	$ 7,000	$ 5,000	$ 2,500	$ 2,000	$ 1,000	$ 27,250
Project 2 Name: *OPERATIONAL INFRASTRUCTURE PROJECT*							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ 4,500	$ 3,000	$ -	$ -	$ -	$ -	$ 7,500
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 2 Total	$ 4,500	$ 3,000	$ -	$ -	$ -	$ -	$ 7,500
Project 3 Name: *TECHNOLOGY PROJECT*							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System	$ 27,000	$ 17,000	$ 12,000	$ 10,000	$ 10,000	$ 9,000	$ 85,000
Technology for Service Delivery	$ 25,950	$ 9,380	$ 9,400	$ 9,400	$ 9,400	$ 9,400	$ 72,930
Other Technology Expenses	$ 5,000	$ -	$ -	$ -	$ -	$ -	$ 5,000
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 3 Total	$ 57,950	$ 26,380	$ 21,400	$ 19,400	$ 19,400	$ 18,400	$ 162,930
Project 4 Name: *[Project title here]*							
DSRIP Goal(s) Addressed: Goal 1:	*Required*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						

Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 4 Total		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 5 Name: *[Project title here]*								
DSRIP Goal(s) Addressed:	Goal 1:	*Required*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 5 Total		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 6 Name: *[Project title here]*								
DSRIP Goal(s) Addressed:	Goal 1:	*Required*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 6 Total		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 7 Name: *[Project title here]*								
DSRIP Goal(s) Addressed:	Goal 1:	*Required*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 7 Total		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Project Costs		$ 72,200	$ 36,380	$ 26,400	$ 21,900	$ 21,400	$ 19,400	**$ 197,680**
Indirect Costs/ Administrative Overhead Rate	10%	$ 7,220	$ 3,638	$ 2,640	$ 2,190	$ 2,140	$ 1,940	**$ 19,768**
Investment Projects Total		$ 79,420	$ 40,018	$ 29,040	$ 24,090	$ 23,540	$ 21,340	**$ 217,448**

CSA Budget Report - Budget Narrative Prep Budget Period

CSA Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name: WORKFORCE DEVELOPMENT PROJECT

DSRIP Project Goal(s):
1 *(3) Improving timely access to ICC services for children eligible to receive ICC ar*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: OPERATIONAL INFRASTRUCTURE PROJECT

DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name: TECHNOLOGY PROJECT

DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care plann*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
CANS Interoperability projects	$ 3,000.00
Wraparound documentation development	$ 5,000.00
Professional service hours	$ 10,000.00
E.H.R. Licenses	$ 9,000.00
Total Development and Adaptation of EHR and Care Management System	$ 27,000.00

CANS Interoperability projects ($3,000) - upgrading our current EHR system to ensure we have interoperability use of the CANS assessment. This will provide our agency the ability to complete the CANS eval and interface the info onto the vertual gateway. This will also enable more efficient data collection and reporting, with a small support overhead since the CANS will be completed within NSMHA EHR. This project will include software licensing, project management, and training.

Wraparound documentation development ($5,000) - NSMHA and its EHR vendor will collaborate on development of a best-practice Wraparound/Strengths-Based documentation module, which will supplement or in some cases replace elements of its existing data-tracking system. Screenings, assessments, plans, and service documentation will be reviewed and potentially updated based on best-practices and fidelity to a strengths-based model. This project is anticipated to include consulting/business analysis, project management, technical development, training, and support.

Professional Services ($10,0000) - funds encompasses our EHR vendors 's projected expenses for their manpower for the expenses listed above.

E.H.R Licenses ($9, 000) - These costs are associated in purchasing further licenses to cover the onboarding of new staff. Current licensing costs are $100 per month, per concurrent user. These funds will allow us to purchase another 8 licenses for the new staff coming onboard.

Technology for Service Delivery

Description of Expense	Cost
Mobile Devices	$ 25,950.00
Total Technology for Service Delivery	**$ 25,950.00**

Mobile devices:
Purchase mobile devices as listed below.
30 iPhone for Family Partners and Care Coordinators(at $50/month each) $1,500/month x 5 months = $7,500
15 laptops for Care Coordinators at $1,230 each = $18,450
Mobile devices will increase the staff meember's ability to input data real time data input

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	**$ -**

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	**$ -**

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Mass HiWay Integration	$ 5,000.00
Total Other Technology Expenses	**$ 5,000.00**

Mass Hiway integration $5,000 to support enrollment and integration of the CSA program with the Mass HIway. Such a project will allow the CSA to interoperate with EOHHS, ACOs, primary care providers, and potentially clients and their families. This project is supported by NSMH's EHR vendor and its Health Information Service Provider (HISP), and will include technical onboarding, project management, and training.

CSA Budget Report - Workforce Development - Prep Budget Period

Project 1 Name: WORKFORCE DEVELOPMENT PROJECT

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost

Project 2 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	**$ -**

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost

Project 3 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	**$ -**

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost

Total Training Expenses	**$ -**

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Staff bonus	$ 9,750.00
Total Retention Expenses	**$ 9,750.00**

Staff Bonus: Funds will be uttlized to assit in retaining 77% of total budgeted ICC staff by providing ICCs, past their 6 month probationary period, bonuses for achieving at least a 95% scores on their TOMS 2.0 collected. A minimum of two TOMS 2.0 will be collected per staff member throughout the fiscal year. Bonuses will be delivered annually after the collection of the TOMS 2.0. Estimated based on 13 ICC staff receiving one time $750 retention bonus.

Total Training Expenses	**$ -**

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	**$ -**

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Total Training Expenses	**$ -**

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	**$ -**

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 1 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost

Project 2 Name: Operational Infrastructure Project

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Data Analyst	$ 60,000.00	0.15	5	$ 3,750.00
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0.15		$ 3,750.00
	Fringe rate	20.0%	Total Fringe	$ 750.00
			Total Program Staffing including Fringe	**$ 4,500.00**

Data Analyst: North Suffolk will 0.15 position work closely with our EHR vendor, eHana, to implement data tracking, dashboarding and reporting necessary to support Quality Measure capture, management and submission in a manner consistent with EOHHS requirements (business analysis, EHR modifications, reporting enhancements and data export integrations).

Description of Expense	Cost

Project 3 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost

Total Other Operational Expenses	**$ -**

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Total Other Operational Expenses	**$ -**

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Total Other Operational Expenses	**$ -**

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate:	**$ 7,220.00**

Provide a brief description of how the Indirect Cost/Administrative Overhead rate was determined:

determined by actual FY18 administration expenses are being allocated per program

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	Investment Project Name	Implementation Goal	Goal Start Date	Anticipated Goal End Date	Investment Category	Investment line Item within Category	PBP Update - Due to EOHHS March 31, 2018				Report on PBP - Due to EOHHS August 31, 2018			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
					Technology	IT Staffing including Fringe								
3	TECHNOLOGY PROJECT	Our scores for Principal 2: Team Based within the MA Wraparound Fidelity Assessment (TOM/TOM 2.0) for year 2018 will increase from 71% to 83%	01/01/18	12/31/18	**Technology**	Development Adaptation of EHR and/or Care Management System	The Full Meeting Attendance marker 1c. on the TOM/TOM 2.0 captured from 1/1/18 to 3/31/18 will increase to 60%	TOM/TOM 2.0 Full Meeting Attendance marker 1c.will increase to 60%			The Full Meeting Attendance marker 1c. on the TOM/TOM 2.0 captured from 1/1/18 to 5/31/18 will increase to 70%	TOM/TOM 2.0 Full Meeting Attendance marker 1c. will increase to 70%		
3	TECHNOLOGY PROJECT	Increase PCP or designee participation at actual care plan meetings to at least 50% via use of video/mobile devices	01/01/18	12/31/18	**Technology**	Technology for Service Delivery	Increase PCP or designee participation at actual care plan meetings to at least 15%	PCP or designee tracker will register a 15% incrrease from 1/1/18 to 3/31/18			Increase PCP participation at actual care plan meetings to at least 25%	PCP or designee tracker will register a 25% incrrease from 1/1/18 to 5/31/18		
3	TECHNOLOGY PROJECT	foster strong integration with our ACOs by conducting 1x per month reviews with ACOs via video/mobile devices	01/01/18	12/31/18	**Technology**	Technology for Service Delivery	minimal 3 monthly reviews with ACOs by 3/31/18	ACO tracker will register at least 3 reviewes from 1/1/18 to 3/31/18			total of 5 monthly reviews with ACOs by end of prep period 5/31/18	ACO tracker will register at least 3 reviewes from 1/1/18 to 5/31/18		
3	TECHNOLOGY PROJECT	Purchase mobile devices for Care Coordinators and Family Partners for real time data input - Mass HIWay, Microsoft	01/01/18	12/31/18	**Technology**	Technology for Service Delivery	All ICCs and FPs will smartphones; All ICCs will have laptops	All staff will received their mobile devices			All ICC laptops will have access to access to MassHIway, eHana and video capability; All staff smartphones will have access to the internet.	Staff will be able to utltize mobile technology to connect to eHana, MassHIway, internet and video capabilites while out in the community.		
					Technology	Other Technology Expenses								
					Workforce Development	Workforce Development staffing including Fringe								
1	WORKFORCE DEVELOPMENT	hire total of 6 staff by 5/31/18	01/01/18	05/31/18	**Workforce Development**	Recruitment Expenses	hire total of 3 by 3/31/18	3 staff hired (2 ICC/1 FP)			hire 6 new staff by 5/31/18	6 staff (3 ICC/3 FP) hired		
1	WORKFORCE DEVELOPMENT	Maintain 90% min NSMHA satisfaction survey score	01/01/18	12/31/18	**Workforce Development**	Recruitment Expenses	90% min NSMHA satisfaction score	NSMHA CBHI satisfaction surveys will mark minimal 90% in all markers			90% min NSMHA satisfaction score	NSMHA CBHI satisfaction surveys will mark minimal 90% in all markers		
1	WORKFORCE DEVELOPMENT	Demonstrate a 50% increase in ICC and FPs posttest scores of understanding how to effectively use the available technology (i.e. EHR, Mass HIway and mobile technology) to further strengthen the overall care planning experience for ICC-Engaged Members.	01/01/18	12/31/18	**Workforce Development**	Recruitment Expenses	30% increase in ICC and FPs posttest scores of understanding how to effectively use the available technology	Staff will having an understanding of: 1. what is the MassHIway, 2. how to utlize the mobil technology to further enhance the wraparound procress, and 3. what are the new features within our EHR system that will also enhance the care planning experience			Staff will demonstrate a 50% increase in posttest score measuring their knowledge on how to effectively use the available technology	Posstest scores dated 5/31/18 will mark 50% increase		
1	WORKFORCE DEVELOPMENT				**Workforce Development**	Recruitment Expenses								
					Workforce Development	Training Expenses								
	WORKFORCE DEVELOPMENT	Retain a minimal of at least 77% of total budgeted ICC staff by providing ICCs, past their 6 month probationary peiod, a bonus for successfully maintaining a 95% score on all TOMS completed.	01/01/18	12/31/18	**Workforce Development**	Retention Expenses	Complete 25% of TOMS on all ICC staff by 3/31/18 to begin to track ICC eligibity for bonus	CSA TOMS sheet will demonstrate 25% of TOMS target number will have been entered			Complete 50% of TOMS on all ICC by 5/31/18 to continue tracking ICC eligibity for bonus	CSA TOMS sheet will demonstrate 50% of TOMS target number will have been entered		
					Operational Infrastructure	Operation Staffing including Fringe								
2	OPERATIONAL INFRASTRUCTURE	Increase our MA WFI-4 Principal 10: Outcome-Based score from 64% to the State Mean % of 69	01/01/18	12/31/18	**Operational Infrastructure**	Other Operational Expenses	The Outcomes-Based Process marker 6d. on the TOM/TOM 2.0 captured from 1/1/18 to 3/31/18 will increase from 82% to 87%	TOM/TOM 2.0 Outcomes-Based Process marker 6d. will increase to 87%			The Outcomes-Based Process marker 6d. on the TOM/TOM 2.0 captured from 3/31/18 to 5/31/18 will not decrease less than 90%	TOM/TOM 2.0 Outcomes-Based Process marker will not decrease less than 90%		
2	OPERATIONAL INFRASTRUCTURE	Maintain at least 70% participation in the Engaged Enrollee Experience Survey	01/01/18	12/31/18	**Operational Infrastructure**	Other Operational Expenses	An Informational sheet for the Engaged Enrollee Experience Survey will have been created and past out to all youth/families enrolled in ICC services.	All families enrolled from 1/1/18 to 3/31/18 will have received the info sheet.			Family Partners will have assisted at least 20% of ICC enrolled families from 1/1/18 to 5/31/18 to complete the Engaged Enrollee Experience Survey	There will be at least 20% of Engaged Enrollee Experience Survey completed by 5/31/18		
2	OPERATIONAL INFRASTRUCTURE	ICC will offer "Date of Initial Appointment" no more than 3 days after initial call at least 90% of the time.	01/01/18	12/31/18	**Operational Infrastructure**	Other Operational Expenses	Families enrolled from 1/1/18 to 3/31/18 will have been offered an initial appointment no more than 3 business days past the the first contact with ICC	RPT update scores from 1/1/18 to 3/31/18 will reflect at least 50% of the time			Families enrolled from 1/1/18 to 5/31/18 will have been offered an initial appointment no more than 3 days past the the first contact with ICC	RPT Update scores from 1/1/18 to 5/31/18 will reflect at least 65% of the time		
2	OPERATIONAL INFRASTRUCTURE	ICC will strive to enroll families into service no more than 7 days after initial phone call at least 85%	01/01/18	12/31/18	**Operational Infrastructure**	Other Operational Expenses	Qualifying youth and families from 1/1/18 to 3/31/18 will have been enrolled into wraparound services no more than 7 business days from the first contact with ICC.	RPT update scores from 1/1/18 to 3/31/18 will reflect at least 40% of the time			Qualifying youth and families from 1/1/18 to 5/31/18 will have been enrolled to wraparound services no more than 7 business days from the first contact with ICC.	RPT Update scores from 1/1/18 to 5/31/18 will reflect at least 65% of the time		

North Suffolk Mental Health Association, Inc.
Proposal for Infrastructure and Capacity Building Funding for CSA
RFR#: 17LCEHSCSAICBFUNDING

6.2 Executive Summary

A. The Bidder's current performance on its Development Plan

North Suffolk Mental Association (NSMHA) is pleased to submit a proposal to MassHealth to strengthen our Community Service Agency (CSA) and support MassHealth's integration efforts through DSRIP funding and ACO implementation. As a long standing community provider of child and family community-based services, North Suffolk is positioned to engage children and their families in a strength-based, child and family-centered, culturally appropriate and trauma-informed approach to the management and integration of behavioral health and primary care.

NSMHA's current Development Plan outlines two goals that seek to improve and enhance our CSA's performance. The first goal focuses on expanding the capacity of our Intensive Care Coordinators (ICC) to integrate and synthesize cultural aspects into their clinical formulations. This goal was developed with Managed Care Entities (MCEs) during the CSA statewide trainings as well as in regional trainings. Our action plan has a specific focus on training staff to capture cultural information and understand its significance in the member's presentation. Staff will be more knowledgeable about the cultures that exist within our catchment area and will be able to translate that knowledge into the Wrap Around and care planning processes. Efforts toward this goal were launched in June of 2017. The second goal in our Development Plan emphasizes increasing timely access to Intensive Care Coordination (ICC) services. To achieve this goal, we must hire new staff in an increasingly competitive employment market. Our Human Resource Department staff partner with managers in the application, vetting, hiring and training processes for new employees and will engage in additional targeted recruitment efforts. In addition, the CSA Program Manager will accompany the Human Resource Recruitment Officer to college/university job fairs to promote the ICC position. In recent months, the CSA has been able to hire five (5) ICC candidates, improving our capacity for timely response to the demands and needs for services.

B. Specific examples of strengths and needs of the Bidder

Our CSA's strength is its connections with our community partners. We often are able to use these connections to provide support to members awaiting ICC services. For example, NSMHA is an active member on the Chelsea Hub, participating weekly in Hub roundtables. Chelsea Hub is an evidence-based, citywide effort to assist at-risk families and/or individuals to connect with services to reduce their immediate risk. The Hub is composed of 30 agencies and serves the citizens of Chelsea. Organizations represented, in addition to North Suffolk, include entities such as the Department of Children and Families (DCF) Harbor Area, Chelsea Police Department, Chelsea Public Schools, Metropolitan Boston Housing Partnership, and the Chelsea District Probation Office. Also working as partners on the Hub are risk-specific agencies such as Community Action Programs Inter-City, Inc., Rosie's Place, Kids in Need of Defense, ROCA, and Chelsea Community Connects. Through the Hub, our CSA connects members with agencies that can assist immediately in reducing a specific risk factor such as eviction, immigration issues, or a law enforcement concern. These connections often stabilize the member so that they no longer need care coordination or result in reducing the immediate risk factor, making the situation safer to allow the member and family to wait for ICC services.

One area of critical need is to increase our current staffing. We have 9 FTE ICCs. To meet the expected service and integration demand, NSMHA estimates needing to increase our team to at least 15 FTE Care Coordinators. Because of the unique cultural make up of our service area and the large number of Spanish speaking youth and families, it is necessary that a majority of our staff be bilingual, more specifically Spanish speakers.

The Bidder's plans for improving timely access to ICC services

Accessibility to services is one of the guiding principles of our organization and we believe that access must be timely, that is, readily available when the individual/family seeks the service. North Suffolk's outpatient behavioral health clinics offer an open access model in which individuals and families are afforded a same day clinical evaluation without the need for an appointment. Our plan for improving timely access to ICC services includes increasing our current staffing numbers, enhancing our Family Partners role in engagement of families and striving for open access and same day availability. DSRIP funding will assist us in implementing marketing and recruiting strategies to hire the staff necessary to accomplish access. This includes partnering with companies like Bayard that develop web-based products that will connect viable candidates to available jobs and careers. We also plan to invest in an MBTA advertising campaign. Many university students in the Boston Metro area use the public transit system and an MBTA campaign would target this population.

The Bidder's plans for improving care coordination, care planning and care management for ICC-Engaged Members

North Suffolk is committed to continuing to improve care coordination, care planning and care management for our ICC-engaged members. We will build our available technology to interface effectively with our ACO partners as well as build operational infrastructure to support this technology. Our capacity to communicate and interface is crucial to effective care coordination to meet the complex needs of our youth and families. It will be important for Care Coordinators to have technology, including video technology, that provides a direct connection with the member's ACO and other care planning team members. This also includes technology such as the Mass HIway where comprehensive assessments, Individual Care Plans, and other information intended to support transitions of care could be transmitted electronically to the ACOs. Additional support tools such as laptops, smartphones and other mobile technology will provide essential connectivity necessary to interface in a timely way from the office, the community or other locations.

A core element to improving the overall care planning experience is ensuring that all parties that provide care to an ICC-Engaged Member are present (physically or virtually) at the meeting for the development of the Individual Care Plan (ICP). This participation not only incorporates providers into the treatment of the member but it also increases their level of accountability. We will accomplish this by utilizing the software that allows several providers to be linked during the process. Improving care coordination includes investing in software such as Microsoft Office 365 that will allow Care Coordinators access to various providers at the same time during a care planning meeting thus improving the treatment planning process. This approach

streamlines the care planning process but saves valuable time as it includes providers who might be unable to be physically present. Time and schedule constraints are a common reason of lack of attendance, particularly for Primary Care Providers (PCP), pediatric personnel, and other personnel from the physical health sector. The identified technology would assist in eliminating that barrier.

E. Bidder's plans to improve performance on quality scores and Development Plan goals

We will improve performance on quality scores and our Development Plan by adding goals that are consistent with MCO requirements and EOHHS's vision. Our CSA Development Plan highlights improved integration between physical, behavioral health, long term services and supports and health related services. To achieve this goal, we will ensure timely access to ICC services by increasing our staffing to meet the demand. Additional goals include focusing on staff training and development, specifically targeting improved quality and responsiveness by strengthening an ICC's abilities to coordinate effectively with ACOs and fine tuning an ICC's ability to collaborate and coordinate with pediatric and behavioral health practices.

Our plans to further improve our quality scores include using the results collected from the Wraparound Fidelity Assessment System Wraparound Provider Practice Analysis (WIPPA), developed by MBHP in collaboration with the Wraparound Evaluation and Research Team in the Department of Psychiatry at the University of Washington. As outlined in the WIPPA the analysis "was developed as a tool for providers to gauge the degree to which their CSAs exhibit wraparound fidelity and to identify strengths and areas for improvement." We will use this analysis, which is completed on a yearly basis, to provide a clear indication as to what areas require further improvement in our implementation of care coordination and collaboration.

F. The Bidder's plans for improving coordination with pediatric primary care and other physical and behavioral health care providers across the care continuum for youth

NSMHA will support enrollment and integration of our CSA into the Mass HIway to assist in improving coordination with pediatric primary care and other physical and behavioral health care providers. This will allow our CSA to connect with EOHHS, ACOs, and primary care providers. This venture will be supported by collaboration with NSMHA's Electronic Health Record (EHR) vendor, eHana, which also has the capability to support scanning, uploading, and securing the exchange of files that can be embedded directly within a member's document history. For smaller pediatric practices or other behavioral health care providers not connected to the Mass HIway, NSMHA will provide members of a consumer's Care Team not employed by NSMHA or other external community providers, controlled access to the enrollee's electronic Care Management record. Such access will be restricted to the minimum necessary level based on demonstrated need for information, documented via Business Associates Agreements and appropriate Disclosures/Releases of Information, and monitored via audit reporting and other means. NSMHA intends to follow industry-standard best practice to comply with HIPAA "Minimum Necessary" requirements restricting unnecessary access to or disclosure of protected health information. Users with appropriate roles and access rights may be granted access to the enrollee's complete record, while others will be restricted to a more limited information set.

6.3 Populations Served and Community Engagement

A. Populations and Communities served

NSMHA CSA's catchment area includes Winthrop, Chelsea, Revere, East Boston, Charlestown and various locations within the Downtown Boston region (eligible zip codes: 02108, 02109, 02110, 02111, 02113, 02114, 02115, 02116 , 02215). Due to NSMHA CSA's current diverse language capacity (i.e. Spanish, Chinese, Portuguese), we frequently receive service requests for youth living in the Malden and Everett areas. We have formed a strong collaboration with the CSA for that specific region and have been able to provide linguistic capacity to youth in need of care coordination within that area. The majority of the families we service are from the Chelsea and East Boston geography and a large percentage of the population we serve represents immigrant families.

NSMHA CSA's plans to promote the health and wellbeing of the individuals it serves and actively initiate and maintain our engagement with them by achieving the following:

1. Adhere to and fully implement Wraparound principles to ensure quality of care to all the families served by our CSA;
2. Provide additional monthly all staff training on care coordination, pediatric medical conditions and community mental health related topics to enhance and maintain the professionalism and expertise of the workforce;
3. Foster and support meaningful integration of behavioral health with primary care;
4. Enhance implementation of the Referral Response Process to ensure all families receive immediate first contact response upon referral being made to the CSA;
5. Participate and engage in community events and conferences to highlight CSA's presence in the community;
6. Advocate for the underprivileged, low-income, immigrant and non-immigrant families we serve;
7. Continue collaborating with local community organizations, schools, child-care providers, youth service organizations, advocacy groups, and state agencies to ensure collaboration progress and explore systemic barriers in order to provide streamlined, consistent, timely quality of care.

B. Community Relationships

The NSMHA CSA long has been embedded in various networking alliances. These alliances not only provide us the inroads to educate the community about our care coordination services but also help us to leverage those relationships to provide assistance to ICC-Engaged youth and their families waiting for ICC services by supporting them to find a solution or alleviate a need. The following list details some of our most successful networking alliances and is not inclusive of all of our community relationships.

- The Education Sector. NSMHA is contracted to provide outpatient school based therapy to the Mario Umana Academy's Middle and Elementary sectors, the Donald McKay, the Phoenix Charter Academy, Abraham Lincoln Elementary and the Susan B. Anthony.

These connections allow us to obtain ready informational access to a youth's overall performance at school, upon consent from caregivers. It also provides leverage for our CSA to guide the family through the educational system as well as strengthen the wraparound fidelity by expediting the coordination process with school. NSMHA CSA is also an ongoing member of the Chelsea High School Community monthly meetings, an avenue utilized by the Chelsea High School to build networking alliances with behavioral health providers within the community. NSMHA leverages Chelsea High School Community meetings to keep their members abreast of any updates within the CSA such as availability of services, language capacity, etc.

- Local Pediatric Clinics. NSMHA meets monthly with the East Boston Neighborhood Health Center (EBNHC) who provides pediatric care to a large percentage of our CSA families. With this established connection, we are able to communicate efficiently and collaboratively with an ICC-Engaged Member's PCP. These meetings provide the opportunity for the mutual sharing of relevant information about a youth's current needs. We have identified a contact person for each department within the EBNHC network of services, streamlining conversations between our CSA and their behavioral and pediatric departments. In addition, NSMHA has partnered with EBNHC to create a Rapid Response Team for the East Boston area. The Rapid Response Team works closely with the East Boston Police Department to provide immediate therapeutic response to individuals involved in a crisis situation. This provides an extra layer of support for our East Boston ICC-Engaged Members involved in crisis situations that require an immediate therapeutic response.
- Department of Children and Family (DCF) Harbor Area. In March 2016, our CSA established monthly meetings with the DCF Harbor Area Office. These meetings have further strengthened the relationship between our CSA and Harbor Area DCF, providing an avenue where NSMHA can discuss active DCF families that are receiving CBHI services. The Program Manager from the CSA and the Program Manger from the In Home Therapy Department meet with the DCF social workers of identified CBHI active clients to provide clinical support and recommendations on any current problems or concerns. This collaboration strengthens the ties between our CSA and DCF and allows our CSA an opportunity to continue to educate DCF on the Wraparound process and how to work with our CSA to make it an effective experience for the CBHI-Engaged member.
- Department of Mental Health (DMH) Metro Boston. As of January 2017, the CSA has been meeting monthly with our DMH Metro Boston Liaison. The DMH Metro Boston Liaison meets with the entire ICC team during the Care Coordinator's one hour group supervision. This provides Care Coordinators the opportunity to discuss and develop action plans for ICC-Engaged Members that require therapeutic support that can only be provided by DMH.
- Chelsea Hub. As described in Section 6.2, the Chelsea HUB is a citywide effort to assist at-risk families and or individuals in connecting with services to reduce their immediate risk. It is comprised of 30 agencies within NSMHA's catchment area and provides services to the citizens of Chelsea. In addition to North Suffolk, the Hub includes entities such as the DCF Harbor Area, Chelsea Police Department, Chelsea Public Schools, Metropolitan Boston Housing Partnership, and the Chelsea District Probation Office. Also represented are risk-specific agencies such as Community Action Programs Inter-

City, Inc., Rosie's Place, Kids in Need of Defense, ROCA, and Chelsea Community Connects. Our CSA utilizes these relationships to connect families with agencies that can assist immediately in reducing a specific risk factor such as eviction, immigration issues, or law enforcement concerns that requires immediate action. NSMHA's CSA has been able to utilize the Chelsea Hub to assist youth currently waiting for ICC services by either stabilizing the situation so that they no longer need care coordination and can be removed from a waitlist for ICC services or the Chelsea HUB has been able to reduce the immediate risk factor making the situation safer to allow the family to wait for ICC services.

- Action for Boston Community Development (ABCD). As described in their website, "ABCD is a non-profit human services organization that provides low-income residents in the Greater Boston region with the tools and resources needed to transition from poverty to stability..." NSMHA, through our CBHI sector, provides on-site therapeutic support to the children attending ABCD's afterschool program. We have allocated a Masters level clinician to attend the school setting to observe and then create action plans to address behaviors exhibited by the children attending the afterschool. The NSMHA clinician meets with the ABCD staff on a weekly basis to provide ongoing clinical support on how to best manage these behaviors. Our clinician also meets with the child to provide individual clinical support. We also provide ABCD with a Care Coordinator who conducts weekly parent support groups for the fathers of the children. We utilize this relationship to establish an internal bridge with ABCD. We are aware that ABCD is one of the largest non-profit human services organizations within East Boston whose resources are invaluable for our ICC-Engaged Members.
- Emergency Services. North Suffolk subcontracts with Boston Medical Center to provide emergency services for the metropolitan Boston area (BEST) and the Cambridge and Somerville geography. North Suffolk provides the mobile crisis and other emergency services for youth and their families.

C. Relevance of Partnerships to Projects

North Suffolk's DSRIP plan includes expanded and holistic training on the complex nature of the conditions in which the members and their families often exist. Our community partnerships and collaborations provide a foundation to improve the overall health of the populations through better integrated interventions and an improved understanding of factors related to health. Increasing the number of ICCs available to work with families and partners and improving their knowledge base, as well as improving the sharing of clinical information will support the improvement in health outcomes for individuals and for the population as a whole. Increasing our ICC staff will also improve the overall care coordination experience of our ICC-Engaged Members. Mobile and video technology will provide Care Coordinators with the immediate capacity to connect with individuals and families, health providers, schools, community-based organizations, advocacy groups, trial courts and other entities that may not be connected to the Mass HIway. With the ability to access our community partners immediately without constraints in location, fidelity to the Wraparound process is strengthened in the aspects of care planning, management and coordination.

6.4. Proposed Project(s) and Investment Plan

North Suffolk proposes projects under each of the identified areas: Workforce Development; Operational Infrastructure; Technology. Through our projects, we will foster strong and meaningful integration with ACOs and primary care providers, continue to strengthen fidelity to the Wraparound process, and provide ready access to the CSA supports provided by our teams of Intensive Care Coordinators and Family Partners.

Workforce Development Project

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Workforce development initiative will include increasing the overall understanding of our staff's ability to use the projected technology projects. Part of providing effective wraparound to families includes the need for staff to understand how to use the available tools that will help them achieve a successful wraparound experience for the families. This means staff needs to be able to understand how to use the Mass HIway and our internal EHR system out in the community to increase the overall care coordination. However understanding and respecting the confidentiality mandates that must be followed.

Staff training efforts will focus on strengthening fidelity to the Wraparound process and enhancing meaningful integration with primary care providers to improve the child and family care experience and the health outcomes of the children engaged in the process. To further strengthen fidelity to Wraparound processes and enhance integration and health outcomes, we will invest time in developing training components that will fortify an ICC's ability to provide high quality care. Onsite training components will include resources designed to teach ICCs about pediatric medical conditions, how to establish a strong working link with an ICC-Engaged Member's ACO and how to promote active participation by the PCP and/or other medical health providers in the member's care planning process. t

As an ongoing effort to improve timely access to ICC services, we will invest some of the funds to retaining our ICC staff that have been trained and are meeting the highest stndards of Wraparound service. The focal point of these funds is to stimulate the *quality* of service an ICC staff member provides to the ICC-Engaged member. This is completely by providing the opportunity for a ICC to earn bonus after their 6 month probation/training period timeslot. In order to qualify for the bonus the ICC staff member must be able to reach a score of 95% on their TOMS rating scales. The Team Observation Measure Version2.0 sheet (TOM 2.0). the TOM 2.0 is an instrument developed by MBHP used to measure the ICC's fidelity to the Wraparound Model. A new ICC will review at least four Tom 2.0 per year. Once the ICC completes the year, they receive two TOM 2.0 per year. The bonus serve a dual process: to stimulate quality of service and encourage ICC to remain with the agency thus improving timely access to service. This is achieved due to the reality that the more ICC staff an agency has on board, the less waitlist times.

A part of our ongoing steps to ensure fidelity to the Wraparound process, we will be providing families annual satisfaction surveys that measure a families overall satisfaction. These markers will be used to tailor training components for Care Coordinators and Family Partners for the purpose of providing feedback to further assist their development.

Phase 1 (Month 1 - 3):

- Develop scoring sheet to be able t measure ICC and FP understanding of available technology (EHR, Mass HiWay, mobile technology)
- k. Begin conversations with union in regards to staff bonuses for quality of care
- Gather first rounds of TOM 2.0
- Finalize interviews with expectation of 3 staff to board by end of month 3

Phase 2 (Month 4 - 7):

- .
- Further strengthen Care Coordinators' ability to integrate with larger entities such as ACOs by developing training and coaching work groups.
- ..
- .

Phase 3 (Month 8 - 10):

- .
- .

Phase 4 (Month 11-12):

- Reconvene Care Coordinator coaching work groups to discuss progress, lessons learned via . training modules to strengthen the interfacing outcomes.

Phase 5 (Years 2-5)

- Assess effectiveness of specific elements of project
- Continue targeted recruitment, as needed, to recruit new staff
- .
- Expand and enhance training .

A4. The proposed outcomes of the project are:

- Hire a total of 6 staff (3ICC/# FP) by the end of prep period 5/31/18 and remain at no less than 70% of budgeted staff capacity for the remainder of the project thus improving timely access to ICC services for children eligible to review ICC services.
- Annual satisfaction surveys collected from consumer, as of launch date 1/2/18, will not dip below 90% of the total satisfaction in our agency's ability to deliver care coordination during the prep period and throughout the remainder of the project.

- Demonstrate a 50% increase in ICC and FPs posttest scotres of understanding how to effectively use the available technology to further strengthen the overall care planning experience for ICC-Engaged Members (i.e. EHR, Mass HIway and mobile technology)
- Retain a minimum of 77% of total budgeted ICC staff by providing ICC, past their 6 month probationary/training period, a monetary bonus for successfully maintaining a 95% score on all TOM 2.0 completed for the year.

A.5. NSMHA's specific use of DSRIP funding is as follows:

- .. Retention bonuses for ICC past their 6 month probationary period who successfully maintaining a 95% score on all TOM 2.0 completed for the year.
- .
- ..

A6. Existing internal resources Bidder plans to use:

North Suffolk will allocate existing staff and build on existing relationships to implement this project. We are prepared to utilize our internal operational infrastructure to support the development, launch and training of staff. Our Information Technology (IT) Department is fully staffed and has expertise in network development and maintenance, IT security management, mobile and desktop devices, hardware and software. We will enlist the assistance of staff with specific expertise based on the element of the project we are implementing. Specifically, our IT staff will train ICCs on how to use the Mass HIway as well as our other proposed projects, including Microsoft Office 365 or comparable software, . and the use of mobile technology. NSMHA will partner with our EHR vendor to support the integration of the Mass HIway into our already existing EHR system.

A7. Explanation of how funds will be allocated across the Bidder's organization and the CSA:

North Suffolk has one CSA site/program. Funds will be allocated to the CSA and all associated revenues will be accounted for within the CSA cost center.

A8. Internal Evaluation, measurement and performance management strategies to demonstrate effectiveness, including plans to collect quantitative and/or qualitative date regarding program activities.

NSMHA will collect and analyze data in the following areas to measure progress and demonstrate effectiveness of the efforts related to this project. Other measures will be added as necessary and appropriate.

- .
- .
- . . Percentage amount of ICC staff that remain past their annual
- Number of ICC hires accomplished.

- Knowledge tests for ICC training .
- Member/family experience satisfaction ratings

Operational Infrastructure Project

North Suffolk will improve and expand our capacity for quality reporting and data analytics and our expertise in using data to drive decision-making and quality improvement initiatives. As part of the DSRIP application, North Suffolk will work closely with our EHR vendor, eHana, to implement data tracking, dashboarding and reporting necessary to support Quality Measure capture, management and submission in a manner consistent with EOHHS requirements. This work may include business analysis, EHR modifications, reporting enhancements and data export integrations for reporting quality measures in a structured format. We will also implement interoperability of the CANS assessment.

Phase 1 (Month 1 -3):

- Review with eHana current capabilities and status of quality measure capture.

Phase 2 (Month 3 - 6):

- Develop measures for tracking, dashboarding and reporting.

Phase 3 (Month 6 -9):

- Identify data elements
- Refine measures
- Develop reports and reporting tools

Phase 4 (Month 10-12):

- Implement
- Review and refine measures, reporting tools, and reports

Phase 5 (Years 2-5)

- Assess effectiveness of specific elements of project
- Continue to develop reports and reporting tools
- Continue to develop quality measures demonstrating effectiveness

A4. The proposed outcome of the project

The proposed outcome of this project is a robust capacity to capture quality measures and the management and submission of reports of those measures consistent with EOHHS requirements.

- Increase our MA WFI-4 Principal 10:Outcome based score from 64% to the State Mean 5 of 69
- Maintain at least 70% participation in the Engaged Enrollee Experience Survey
- ICC will offer "date of Initial Appointment" no more than 3 days after initial call of at least 90% of the time
- ICC will enroll families into service no more than 7 days after the initial phone call of at least 855 of the time.

A.5. NSMHA's specific use of DSRIP funding is as follows:

- Upgrade our current EHR system and other data systems to ensure the capacity to capture and report on relevant measures. Implementation of this project may include technology licensing, project management, training, and support. Connection to the Mass HIway (part of the Technology Project) will provide our CSA the capacity to prepare and share information and reports internally and also to share securely with ACOs, MCOs and EOHHS and other pediatric and/or behavioral health practices connected to the Mass HIway.
- Purchase mobile devices for Care Coordinators and Family Partners for real time data input. This will provide Care Coordinators immediate access to the Mass HIway while in the community as well as access to their secured Microsoft Outlook email accounts and will result in improved integrity of data, enhanced integration efforts and stronger fidelity to the Wraparound process.
- Implement interoperability of the CANS assessment with our EHR vendor, eHana. North Suffolk anticipates utilizing functionality when it is deployed. This will enable more efficient data collection and reporting, with a small support overhead since the CANS will be completed within our EHR. This part of the project will include software licensing, project management and training.

A6. Existing internal resources Bidder plans to use:

North Suffolk will allocate existing staff and build on existing relationships to implement this project. We are prepared to utilize our internal operational infrastructure (i.e. IT workforce) to support the development, launch and training of staff on how to use the Mass HIway as well as our other proposed projects, including Microsoft Office 365, the web-based library and the use of mobile technology. NSMHA will partner with our EHR vendor to support the integration of the Mass HIway into our already existing EHR system.

A7. Explanation of how funds will be allocated across the Bidder's organization and the CSA:

North Suffolk has one CSA site/program. Funds will be allocated to the CSA and all associated revenues will be accounted for within the CSA cost center.

A8. Internal Evaluation, measurement and performance management strategies to demonstrate effectiveness, including plans to collect quantitative and/or qualitative date regarding program activities.

Quality and accountability measures technology will support:

- Claims/Encounter Only Measures. North Suffolk will work with eHana to automate, where possible, the import/collection of quality data (including, for example, data supplied by EOHHS). Where possible, North Suffolk will work with EOHHS, ACOs, MCOs, other health care providers, and community stakeholders to build data interchanges to support real-time quality analytics.
- Chart Review Measures. North Suffolk will use existing tools and technologies such as login audits, encrypted PDF exports, and data analytics to support submission of the Quality Measures Report to EOHHS and to provide access to additional data or information necessary to audit or validate submitted data.
- Engaged Enrollees Experience Survey. North Suffolk will support EOHHS in the implementation of the Engaged Enrollee Experience Survey and will actively encourage members and families to participate.

Technology Project

To develop and enhance integration with ACOs and primary care providers, we will utilize DSRIP funding to build upon our already existing technology. By purchasing laptops, tablets and smartphones for Care Coordinators, we will increase the Care Coordinators' capacity to interface immediately with ACOs and primary care providers while out in the community.

We also will utilize DSRIP funds to connect to the Mass HIway in order to share information securely. This endeavor is supported by our EHR vendor, eHana, and will include technical onboarding, project management, and training. We will expand our use of Microsoft Office 365 to provide Care Coordinators the capacity to access various providers at the same time during a care planning meeting thus targeting not only integration with ACOs but also strengthening fidelity to Wraparound processes specifically during the care planning process.

A3. The startup scope of the project is as outlined:

Phase 1 (Month 1 - 4):

- Invest in technology supports to support the increased integration demanded of the project by upgrading our current EHR system to connect to the Mass HIway. This will include technical onboarding, project management, and training.
- Invest in mobile technology to increase Care Coordinators ability to interface efficiently. Purchase smart phones and laptops for all current and budgeted Care Coordinators and

provide training on how to effectively utilize the mobile technology to support the interfacing endeavor.

Phase 2 (Month 5 - 8):

- Invest in Microsoft Office 365 or comparable software.
- Train staff on how to utilize system.

Phase 3 (Month 9 - 12):

- Continue to work with our EHR vendor to problem solve any issues concerning the integration to the Mass HIway.

Phase 4 (Years 2-5)

- Assess effectiveness of specific elements of project
- Explore additional technology advancements and enhancements to improve coordination, integration and outcomes

A4. The proposed outcomes of the project are:

- Our score for Principal 2: team based withih the MA Wraparound Fideltity Assessment (TOM 2.0) for year 2018 will increase from 71% to 83%
- Increase PCP or designee participation at actual care plan meetings to at least 50% via use of video/mobile devices
- . Foste stronger intergration with our ACOs by conducting 1x per month reviews with ACOs via use of video/mobile devices
- . Purchase mobile devices (30 I-phones, 15 laptops) for Care Coordaintor and family Partners for real time data imput (Mass HiWay, EHR)

A.5. NSMHA's specific use of DSRIP funding is as follows:

- Upgrade our current EHR system to connect to Mass HIway. Implementation of this project includes technology licensing, project management, training, and support. Connection to the Mass HIway will provide our CSA the ability to share information securely with an ICC-Engaged Member's ACOs and other pediatric and/or behavioral health practices connected to the Mass HIway. Thus this particular use of funding will foster a stronger integration with said providers.
- Purchase mobile devices for Care Coordinators and Family Partners, providing Care Coordinators immediate access to the Mass HIway while in the community as well as access to their secured Microsoft Outlook email accounts. This real time capacity to connect will support integration efforts and will strengthen fidelity to the Wraparound process as Care Coordinators will have the available avenues to connect with providers to ensure they are integrated into the planning and care of the ICC member and their family.

- Purchase smartphones for Care Coordinators and Family Partners which will allow a Care Coordinator to immediately respond to a crisis, improving the care management, care coordination and care experience process for an ICC-Engaged Member.
- Purchase Microsoft Office 365 or comparable software that will ensure the virtual (video) presence of providers during the care planning process thus improving integration and Wraparound processes.

A6. Existing internal resources Bidder plans to use:

North Suffolk will allocate existing staff and build on existing relationships to implement this project. We are prepared to utilize our internal operational infrastructure (i.e. IT workforce) to support the development, launch and training of staff on how to use the Mass HIway as well as our other proposed projects, including Microsoft Office 365, the web-based library and the use of mobile technology. NSMHA will partner with our EHR vendor to support the integration of the Mass HIway into our already existing EHR system.

A7. Explanation of how funds will be allocated across the Bidder's organization and the CSA:

North Suffolk has one CSA site/program. Funds will be allocated to the CSA and all associated revenues will be accounted for within the CSA cost center.

A8. Internal Evaluation, measurement and performance management strategies to demonstrate effectiveness, including plans to collect quantitative and/or qualitative date regarding program activities.

NSMHA has substantial demonstrated experience successfully managing implementation, deployment, and support of electronic health records and other electronic means of tracking and using data to guide decision making and quality improvement. Our EHR vendor, eHana's Software-as-a-Service (SaaS) EHR, which is certified Meaningful Use Complete by Drummond Group (Certification Number 14.04.04.2594.eHan.16.0.1.160728) has been deployed in community-based provider organizations throughout Massachusetts. Our CSA implemented the electronic record in 2016. As part of this project, we will implement additional functionality within our EHR to manage and track services delivered, referred, and coordinated within our CSA and associated programs. We have already deployed our EHR technology in multiple sites and we have a strong record of success with technology adoption in similar programs. The ONC-Certified version of the eHana EHR includes features and functionality intended to support integrated and collaborative models of care, including Patient Portal functionality, Standardized data exchange formats (including Clinical Document Architecture (CDA) support), Transmission via DIRECT Health Information Service Provider (HISP) to the Mass HIway or other partners, Clinical Quality Measure and Automated Measure reporting and Patient Educational Resource sharing and tracking. These features support EOHHS's goal of developing secure mechanisms to support data exchange not only with EOHHS and payers, but with the ICC-Engaged Members themselves. By way of example, comprehensive assessments, Individual Care Plans, and other information intended to support transitions of care could be shared via the Patient Portal or transmitted electronically via the Mass HIway. As part of the DSRIP application, we will work

closely with our EHR vendor, eHana, to implement data tracking, dashboarding, and reporting necessary to support Quality Measure capture, management, and submission in a manner consistent with EOHHS requirements. This work may include business process analysis, EHR modifications, reporting enhancements, and data export integrations (for reporting quality measures in a structure format). NSMHA will work with eHana EHR to automate, where possible, the import/collection of quality data (including, for example, data supplied by EOHHS). Where possible, we will work with EOHHS, ACOs, MCOs, other health care providers, and community stakeholders to build data interchanges to support real-time quality analytics.

B1. An organizational chart of the Bidder (as attachment).

NSMHA's current organizational chart is located in Attachment A.

B2. The following is a list of staff that will be involved in the execution of the proposed projects. This will be the core team for the planning, implementation and management of each of the proposed projects is highlighted with all others working on each project as their talents and expertise and project needs dictate. Ms. Lemoine has the authority to approve project plans, assign elements of the projects, and allocate resources, including additional resources, as needed.

Judi Lemoine, RN BSN – Chief Operating Officer - As the COO, Ms. Lemoine is responsible for all administrative and related activities including management of the human, fiscal, physical, and community resources necessary to ensure that service programs are planned and managed to the highest standards of the industry. Ms. Lemoine has worked for North Suffolk for more than 25 years.

Esmeralda Porto, LICSW - Director of Community Based Services - Ms. Porto was the Director of the NSMHA CSA for three (3) years prior to assuming her current role in June 2017. Prior to assuming the role of Director of CSA, Ms. Porto worked in the field as a Care Coordinator for four (4) years.

Hanying Pu, LMHC - Director of the Community Service Agency - Ms. Pu was employed as a Care Coordinator for five (5) years before assuming the Director of the CSA role.

Julio Vazquez – Chief Information Officer - Mr. Vazquez has coordinated all technology infrastructure projects for NSMHA since joining North Suffolk in 2000.

Yovanny Reinoso – Director of Applications & Data Management – Mr. Reinoso has managed various operational infrastructure and implementation projects such as the implementation of our electronic records and the implementation of our electronic timekeeping system, Kronos.

Kang Zheng – EHR Application Support Specialist – Under the direction of the Director of Applications & Data Management, Mr. Zheng is the liaison for our current EHR system. He is responsible for providing solutions to all problem-based issues staff experience that involves our EHR system, eHana.

Edward Ojeikere - IT Support Specialist - Currently Mr. Ojeikere is responsible for the day-to-day operations of all of NSMHA telephone access and connectivity.

Jason Romero – Director of Human Resources – Mr. Romero coordinates various marketing projects for NSMHA to increase recruitment efforts.

Deb Snow, CHC - Director of Compliance and Quality Management – Ms. Snow and her team ensure compliance with HIPAA and other applicable privacy and security laws and regulations, oversee the organization's Human Rights program, work with all departments on quality measures, data analysis and quality improvement efforts, and manage the organization's risk data base.

B3. Any staff the Bidder proposes to hire or engage to be involved in the project.

At this point, North Suffolk plans to allocate existing staff to the management and implementation of these projects.

B4. The following is list of the roles and responsibility of NSMHA Project Team:

Judi Lemoine – Chief Operating Officer. The Chief Operating Officer will provide management oversight of the required accountability to ensure that goals outlined by MassHealth and EOHHS for application of the DSRIP funding are met.

Esmeralda Porto, LICSW - Director of Community Based Services. Under the leadership of the Chief Operating Officer, the Director of Community Based Services will be responsible for ensuring that the proposed outcomes outlined in Section 6.4-A.4. are achieved. Under the direction of the Chief Operating Officer, the Director of Community Based Services will also drive the implementation of the project within the CSA department via the Director of the Community Service Agency.

Hanying Pu, LMHC - Director of the Community Service Agency. Under the direction of the Director of Community Based Services, Ms. Pu will oversee the direct training of the Care Coordinators to further strengthen and develop their ability to interface with physical health, behavioral health, long–term services and supports and health-related social services. She will work closely with the Director of Community Based Services and NSMHA's IT workforce involved in the project to learn the new technology and software being launched in order to support the CSA with their development.

Julio Vazquez – Chief Information Officer. Mr. Vazquez' responsibility will include organizing NSMHA's IT workforce to be able to meet the timelines outlined within the scope of the project.

Yovanny Reinoso – Director of Applications & Data Management. Under the direction of the Chief Information Officer, Mr. Reinoso will be responsible for the creation and execution of the web-based library and collaborating with our current EHR vendor for connections to the Mass HIway.

Kang Zheng – EHR Application Support Specialist. Under the direction of Director of Applications & Data Management, Mr. Zheng will be responsible for staff trainings on the use of the Mass HIway via our EHR system.

Edward Ojeikere - IT Support Specialist. Under the director of the Chief Information Officer, Mr. Ojeikere will be responsible for the execution of Microsoft Office 365 or comparable system as well as training the Director of Community Based Services and the Director of the Community Service Agency on how to use the system so they in turn are able to train the CSA staff.

Jason Romero – Director of Human Resources. As director of our Human Resources Department, Mr. Romero will be responsible for connecting with Bayard for the creation and execution of the purposed landing page and overseeing the MBTA campaign launch as outlined in the project description.

Deb Snow, CHC - Director of Compliance and Quality Management. The Director of Compliance and Quality Management will work closely with our IT department and our EHR vendor, eHana, to ensure data sharing between NSMHA CSA and ICC-Engaged Member's ACOs, primary care, physical, behavioral health providers meet compliance standards according to HIPAA and other applicable privacy and security laws and regulations. In addition, Ms. Snow and her staff will assist with the development of quality and outcome measures and reporting.

The Project Team will meet on a monthly basis to ensure that efforts are coordinated among the staff and not duplicated. NSMHA will use these monthly meetings to strategize next steps, review progress and accountability on tasks created and problem solve any barriers faced during the process.

B5. Under the direction of the Chief Operating Officer, the Director of Community Based Services will oversee the management of this project. The Director of Community Based Services will ensure the tasks assigned during internal monthly meetings are being met and that target dates are being achieved as planned. The Director of Community Based Services will also coordinate with the Project Team members to strategize the momentum towards the EOHHS's vision of use of the DSRIP funds.

C. **Implementation Plan and Timeline**.

August, 2017

- Award notification.
- Develop necessary agreements.
- Notify and initiate meetings with ACOs.

September – November 2017. Design and planning

December, 2017 – February, 2018.

- Design and planning.
- Develop sharing via Mass HIway

March 2018.

- Installation
- Training for CSA ICC staff
- Work with ACOs and affiliated PCCs to share information via Mass HIway
- Initial purchase of mobile devices

April – June 2018

- Second round of purchase of mobile devices.
- Share care plans with PCCs

July 2018

- Generate aggregated reports

August – December 2018 (and beyond)

- Continued implementation
- Problem-solving
- Reporting and information sharing with PCCs, ACOs and MCOs

D. Budget Report and Budget Narrative:

The budget documents can be found at Attachment B (Budget) and Attachment C (Budget Narrative).

E. Sustainability:

North Suffolk understands that the DSRIP funding for the CSA is designed decrease over the course of the five year contract. We intend to work actively and diligently with our ACO partners to ensure a transition that sustains and supports the infrastructure, the model of integrated care coordination and care planning, and the positive health outcomes we expect to achieve.

We anticipate that the state will complete its move to an alternative payment methodology for all CSAs resulting in increased efficiencies of documentation, enhanced effectiveness of staff and improved retention of care coordination staff. To the extent other alternative payment

methodologies are implemented, the administrative burden associated with current mechanisms may be reduced and allow for redirection to support sustainability.

We anticipate that we will be serving a larger number of children and families as a result of increased communication, connection and integration with primary care practitioners. An increase in our volume (presuming a sufficient reimbursement rate) will result in increased internal resources and administrative allocation to support maintenance costs associated with any software and devices purchased.

The Behavioral Health Community Partner concept is built on the assumption that Community Partners will be able to demonstrate their value to their ACO partners by integrating into the service system in such a way that its members experience accessible, seamless and competent care that results in improved health and reduced overall cost. As we are able to participate more fully as partners in the goal of improved population health and reduced overall cost and demonstrate the effectiveness of our part of the integration effort, it would be our goal to also participate in the risk sharing and incentives built into the system long term.

6.5 Coordination with ACOs, MCOs and Primary Care Providers

A. Bi-directional communication. Currently, our CSA relies heavily on fax, voicemail and secured emails to remain connected with pediatric practices. In our experience, the most reliable form of communication has been the fax. This may be due in part to pediatric practices' use of their frontline office personnel to cover communication and in part to the minimal amount of time it takes to use. For example, the return rate for the Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form, a communication form created by the MCEs to facilitate communication between an ICC and an ICC-Engaged Member's PCP, is much higher than the response rate for a PCP's attendance to a care plan meeting. Communication via fax is not the most effective mechanism when dealing with time sensitive information. The overall vision is to move away from the current archaic standard to a more effective and innovative system. The implementation of the Mass HIway will move our CSA closer to this vision. The timely sharing of information can be achieved using this tool and Care Coordinators will also having immediate access to health care providers to share relevant information in regards to the ICC-Engaged Member's treatment planning. This will increase bidirectional communication between the ICC and health care providers and will also assist encouraging the integration of healthcare providers into the care planning process for the ICC-Engaged Member.

For smaller pediatric practices that may not be connected to the MassHIway, NSMHA will work with these practices to build practical methods to support interfacing efforts. As outlined in Section 6.2, NSMHA is prepared to provide members of an ICC-Engaged Member's Care Team not employed by NSMHA or other external community providers, limited access to the enrollee's electronic care management record. This access will be restricted to the minimum necessary level based on demonstrated need for information. We will continue to comply with HIPAA "Minimum Necessary" requirements that restrict the release of unnecessary access to, or disclosure of, protected health information. When interfacing with smaller pediatric and behavioral health practices, NSMHA will evaluate each individual and their roles to determine who requires access to the record and the parameters of that access. Care Plan Team members with appropriate roles and access rights may be granted access to the enrollee's complete record, while others may be restricted to a more limited information set. Creative use of our current EHR will not only increase bidirectional communication between the CSA and smaller pediatric practices but will meet the EOHHS's vision of creating stronger and more meaningful integration between providers for ICC-Engaged Members.

Other standardized practices include building a direct face-to-face relationship with the smaller pediatric practices. Smaller pediatric practices typically have fewer office personnel so that it is often effective to develop a relationship with that one person and/or frontline office staff that has a direct link with that pediatric provider. Establishing a working relationship with those key personnel and creating monthly meetings with them, is another useful tool in streamlining this endeavor with smaller pediatric practices not connected to the Mass HIway.

B. Referral management. The CSA Program Manager will ensure the development of and adherence to referral management protocols and will oversee follow-up and information sharing

practices. NSMHA will work closely with our current EHR vendor, eHana, to develop forms, workflows, processes, reports, and data extracts that will assist in reporting, collaboration and coordination with ACOs, MCOs, and primary and pediatric care practitioners. Currently eHana EHR is able to provide centralized tracking and reporting of enrollment and admissions as well as inpatient admissions, incarceration, homelessness events, and other life events. eHana EHR also features a built-in-library of reports that can be accessed to provide advanced analytics. This option can be utilized to isolate numbers to assist the CSA in identifying which pediatric practices are commonly used by NSMHA's ICC-Engaged Members. NSMHA can then use these data to invest time and resources to establishing stronger links with those specific pediatric practices.

With regard to information sharing among ACOs, MCOs, and primary and pediatric care practices, NSMHA is committed to the secure exchange of data and compliance with HIPAA and other applicable privacy and security laws and regulations. Approaches to supporting secure exchange of data include:

(a) **Authentication**. NSMHA uses industry-standard best practices to ensure authentication of both Care Management/EHR system access (via username and password, with required complexity rules, reset timelines, and auto-logoff) and automated data exchange (using certificate-managed XDR/SMTP, trust anchors, and other mechanisms as appropriate).

(b) **Encryption**. NSMHA currently leverages robust encryption technology to secure all transmissions of Protected Health Information, including both symmetric and asymmetric Public Key Infrastructure techniques such as Secure Sockets Layer.

(c) **Integrity**. Where possible, NSMHA utilizes hashing and other technologies to ensure message integrity in transit. The Direct Project standard, for example, with which eHana EHR complies, mandates that message integrity be protected using industry-standard SHA hashing techniques.

C. Team-based treatment planning. NSMHA will utilize technology and software outline in Section 6.4 - A.5. to improve Team-based treatment planning in collaboration with pediatric practices as follows:

1. NSMHA will utilize Microsoft Office 365 (or comparable software) technology with video capability to increase the likelihood of pediatric provider's ability to attend a care planning meeting virtually, if not in person. With this software NSMHA can provide a PCP an opportunity to engage in the care planning process without having to leave their offices thus increasing the possibility of pediatric provider involvement in the care planning process. We will also strive to schedule care planning meetings at times most convenient for provider partners.

2. NSMHA will use the Mass HIway as a secure avenue of information exchange between the CSA and pediatric practices. For smaller pediatric practices not connected to the Mass HIway, NSMHA is prepared to provide ICC-Engaged Member's PCP limited access to the enrollee's electronic care management record. This access will be restricted

to the minimum necessary level based on demonstrated need for information for the sole purpose of improving ICC-Engaged Member's PCP ability to collaborate fully in the care planning process.

3. NSMHA will utilize eHana EHR built-in-library feature to identify commonly utilized pediatric care providers by NSMHA ICC-Engaged Members. NSMHA will then invest resources to establish stronger links with the identified pediatric providers to improve Team-based treatment planning.

D. Timely access to ICC services. We are committed to improving timely access to ICC services by substantially increasing the size of our current CSA workforce. Timely access to ICC services is directly related to the CSA's ability to meet the demand of the service. NSMHA will continue to utilize its current use of its external advertising sources (i.e. Monster, Indeed, etc.) and will invest in innovative marketing strategies such as landing pages and MBTA advertising campaigns that will target qualified candidates.

E. Connections to social services. NSMHA will continue to rely on our CSA's well-established relationships within our community to maintain connections to social services. This includes:

1. Continued support for the monthly on-site visits by Metro Boston DMH Liaison. NSMHA will leverage these meetings to connect ICC-Engaged Members to DMH services, if needed.

2. Continued support for the CSA's monthly consultation with the Harbor Area DCF office. The monthly consultation has created a direct pipeline of communication between NSMHA CSA and the Harbor Area DCF office where ICC-Engaged Members involved with DCF can be discussed.

3. Continued support of the CSA's System of Care Committee (SOCC) meeting. NSMHA will utilize the SOCC meetings as an avenue to remain connected with the community's various social services who regularly attend. As outlined in the CSA Program Description and Operations Manual the SOCC is a "cross-system, coordinated network of services and supports organized to address the complex and changing needs of youth and families." The SOCC is hosted by the Director of the CSA and is held on a monthly basis. Active social service participants include the Chelsea District Probation Office, Harbor Area DCF, DMH Metro Boston and Department of Youth Services.

CSA Budget Report

Riverside Community Care, Inc.

Investment Funding	Prep Budget Period - 1/2/18-5/31/18	Budget Year 1 - 6/1/18-12/31/18	Budget Year 2 - 1/1/19-12/31/19	Budget Year 3 - 1/1/20-12/31/20	Budget Year 4 - 1/1/21-12/31/21	Budget Year 5 - 1/1/22-12/31/22	Total Revenues
Number of CSA sites	2	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate	NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)	173	173	173	173	173	173	
Estimated Funds	$ 176,052	$ 121,100	$ 72,660	$ 51,900	$ 45,672	$ 20,760	**$ 488,144**
At- Risk Withhold Rate			5%	10%	15%	20%	
Withhold			$ 3,633	$ 5,190	$ 6,851	$ 4,152	**$ 19,826**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 176,052	$ 121,100	$ 69,027	$ 46,710	$ 38,821	$ 16,608	**$ 468,318**

Investment Projects	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Project 1 Name: *Information Technology*							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ 11,190	$ -	$ -	$ -	$ -	$ -	**$ 11,190**
Development Adaptation of EHR and/or Care Management System	$ 69,152	$ 9,506	$ -	$ -	$ -	$ -	**$ 78,658**
Technology for Service Delivery	$ 75,750	$ 48,350	$ -	$ -	$ 6,450	$ -	**$ 130,550**
Other Technology Expenses	$ -	$ -	$ 12,000	$ -	$ -	$ -	**$ 12,000**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 1 Total	$ 156,092	$ 57,856	$ 12,000	$ -	$ 6,450	$ -	**$ 232,398**
Project 2 Name: *High Fidelity Wraparound*							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ 6,000	$ -	$ -	$ -	$ -	**$ 6,000**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ -	$ 6,420	$ 19,854	$ 33,454	$ 19,251	$ 5,600	**$ 84,579**
Retention Expenses	$ -	$ 31,989	$ 24,955	$ 4,342	$ 5,968	$ 3,255	**$ 70,509**
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 2 Total	$ -	$ 44,409	$ 44,809	$ 37,796	$ 25,219	$ 8,855	**$ 161,087**
Project 3 Name: *Training and Consultation*							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ -	$ 3,000	$ -	$ -	$ -	$ -	**$ 3,000**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses	$ 2,900	$ 4,100	$ 8,810	$ 9,074	$ 9,347	$ 9,627	**$ 43,858**

Project 3 Total		$ 2,900	$ 7,100	$ 8,810	$ 9,074	$ 9,347	$ 9,627	**$ 46,858**
Total Project Costs		$ 158,992	$ 109,365	$ 65,619	$ 46,870	$ 41,015	$ 18,482	**$ 440,343**
Indirect Costs/ Administrative Overhead Rate	10.73%	$ 17,060	$ 11,735	$ 7,041	$ 5,029	$ 4,401	$ 1,983	**$ 47,249**
Investment Projects Total		$ 176,052	$ 121,100	$ 72,660	$ 51,899	$ 45,416	$ 20,465	**$ 487,592**
Under spend / (Over spend) Includes Admin		$ 0	$ 0	$ 0	$ 1	$ 256	$ 295	**$ 552**
We can actually spend this--->		$ 0	$ 0	$ 0	$ 0	$ 231	$ 266	**0.1%**

CSA Budget Report - Budget Narrative Prep Budget Period

CSA Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name: Information Technology

DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E*
2 *(2) Strengthening fidelity to Wraparound processes, including the care planning*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
CIO	$ 174,990.40	0.1268772	5	$ 9,251
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0.1268772		$ 9,251
	Fringe rate	21.0%	Total Fringe	$ 1,939
			Total IT Staffing including Fringe	**$ 11,190**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.
Riverside's CIO, Charley O'Neill will be responsible for overseeing project and for hiring/overseeing consultant. Included in this amount is 24 hours/month of his time. Charley has 35 years of experience developing Enterprise Application Systems both as a user and a vendor. He brings 9 years of direct experience in the development and deployment of the MDMI data exchange Standard. His experience coupled with the expertise of a consultant will assist in the successful implementation of care management software applicable to the CSA and/or development of electronic exchange with non-ACO based providers such as independent PCPs, other Behavioral Health agencies, and other key providers, and establishing the client consent methodologies required. The implementing of care management software and establishing exchange connections is critical in providing high fidelity wraparound services and allows for strong integration with ACO's, primary care providers and other providers for ICC-engaged members.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
IT Project management consultation	$ 69,152.00
Total Development and Adaptation of EHR and Care Management System	**$ 69,152.00**

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:
A consultant hired by our CIO will have expertise that will assist in the successful implementation of care management software applicable to the CSA and/or development of electronic exchange with non-ACO based providers such as independent PCPs, other Behavioral Health agencies, and other key providers, and establishing the client consent methodologies required. The implementing of care management software and establishing exchange connections is critical in providing high fidelity wraparound services and allows for strong integration with ACO's, primary care providers and other providers for ICC-engaged members. The $69,152 allocation will be distributed equally between each CSA and will be utilized in one of two ways: for extended integration of Providers (beyond those who we will integrate through our BH CP project) and/or for establishing an electronic care management record for use by our two CSA programs. We are likely to utilize some of this funding for each of these projects.
The cost of extending integration to Providers relevant for the CSA would be achieved as follows:
Each EMR integration will require 50 hours of planning, development, and testing by the consultant company. At $90.00 per hour, each integration will cost $4,500.
The $69k will cover the addition of 15 additional EMR types. Note that each type might be used by multiple providers, meaning that the total connectivity obtained will be greater than the 15.
As noted above, we are also considering using some of this money to capture CSA programs within an electronic care management solution, either *Evolv* or *Care Navigator*. Funding of Care Navigator or for adapting Evolv for CSA specific requirements will reduce the number of EMR

Technology for Service Delivery

Description of Expense	Cost
Computer equipment for 35 Staff	$ 75,250.00
5 printers	$ 500.00
Total Technology for Service Delivery	**$ 75,750.00**

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:
$75,250.00 is budgeted for investment in computer equipment to allow us to supply 35 (17 to our Cambridge CSA and 18 to our Arlington CSA)of our CSA employees with state of the art mobile technology, equipped with our cloud-hosted EHR, MyEvolv from Netsmart Technologies or other software as may be determined. At approximately $2,150 per equipment set-up with currently available pricing, it will include a Dell Latitude E5470, Hotspot, antenna, signature pad, printer for printing in field sites, wireless keyboard and remote mouse, and carrying bag, as well as desktop monitors, docking stations, access to the MyEvolv EHR, access to a common networked shared drive and access to all standard Riverside employee related administrative applications.

Another $500 will purchase 5 small wireless printers that will alllow staff to print documentation in the field for families and providers. This will be particulary useful for staff to have the ability to print materials during Care Planning Meetings. 2 printers will be purchased for our Cambridge CSA and 3 printers will be purchased for our larger Arlington CSA program. Having the appropritate technology available is critical in providing high fidelity Wraparound services. Having quicker means of connection with providers and immediate access to documentation is vital and meets both goals for this project.

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	**$ -**

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: High Fidelity Wraparound

DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care planni*
2 *(3) Improving timely access to ICC services for children eligible to receive ICC*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	**$ -**

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	**$ -**

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	**$ -**

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name: Training and Consultation

DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care planni*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	**$ -**

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	**$ -**

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	**$ -**

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Workforce Development - Prep Budget Period

Project 1 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	**$ -**

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	**$ -**

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	**$ -**

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 1 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate	0.0%	Total Fringe	$ -
			Total Program Staffing including Fringe	**$ -**

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Child Psychologist Consultant	$ 2,900.00
Total Other Operational Expenses	**$ 2,900.00**

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:
Dr. Tyrone Williams will be providing consultation to both CSA sites. This consultation will be different from what our current psychiatry consultation entails. It will focus specifically on medical issues such as interactions between chronic medical conditions and psychiatric conditions, chronic pain management, eating disorders, and coaching and assisting staff to better coordinate with pediatricians and medical specialists etc. During this prep period, the psychiatrist will utilize some of the consultation time for meeting with managers for planning purposes for the ongoing program consultation. Estimated 29 hours during a five month period at $100/hr
Dr. Williams will meet with each CSA for 14.5 hours during the prep period.
2.5 hours will be dedicated to each CSA in month one for Dr. Williams to meet with Program Directors and management staff to determine the needs of the individual teams. 3 hours of consultation will be dedicated in months 2-5 for each CSA (12 hours each).

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate: **$ 17,060.00**

Provide a brief description of how the Indirect Cost/Administrative Overhead rate was determined:

The rate is Riverside's FY18 budgeted general and administrative overhead/indirect cost rate applied consistently across all Riverside programs*:*

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS March 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
					Technology	IT Staffing including Fringe								
1	Information Technology	Purchase and equip CSA staff with mobile technology for service delivery	08/01/17	12/31/21	**Technology**	Development Adaptation of EHR and/or Care Management System								
					Technology	Technology for Service Delivery	Mobile devices for 35 staff will have been delivered	All equipment received by staff; documentation of billing receipts			All 35 staff will have the appropiate technology for service delivery	All equipment received and configured		
					Technology	Other Technology Expenses								
					Workforce Development	Workforce Development staffing including Fringe								
					Workforce Development	Recruitment Expenses								
					Workforce Development	Training Expenses								
					Workforce Development	Retention Expenses								
3	Training and Consultation	Psychiatric consultation related to medical issues.	01/01/18	12/31/22	**Operational Infrastructure**	Operation Staffing including Fringe								
					Operational Infrastructure	Other Operational Expenses	Consultant will have met with program directors to understand the needs of each CSA and initial consultations will have started.	Consulted will have met with program directors. Meetings will be documented/tracked.			Regular and ongoing consultations will have begun.	Meetings documented/tracked		
					Operational Infrastructure									
					Operational Infrastructure									

Attachment C: CSA Budget Narrative

Budget Expenses:

(Investment narrative should only include investments listed in the Budget Report provided on Attachment B. Please provide separate descriptions of budget allocations for each project)

Workforce Development **Total:** $161,087

In the box below, please provide a description of all items within the Workforce Development investment category (e.g. recruitment support, training and coaching programs and certifications). Please be sure to specify the goals and project(s) this investment will support, as described in **Section 3.4** and **Section 6** of the RFR and how these investments will assist in meeting the terms of the Contract.

Prep Budget Workforce Development Investments:

N/A

Year 1 Budget Workforce Development Investments: $44,409

In budget year 1, we plan to utilize $37,989 to support the workforce in both of our CSAs to achieve High Fidelity Wrap Around Certification. We intend to provide a $500 stipend for staff who complete Tier I Certification (estimated to be 14 staff in our Somerville based CSA and 19 in our Needham based CSA) and $1000 stipend for staff who complete both Tier I and Tier II (estimated to be 5 staff per site). To accomplish this we have budgeted $6,000 as stipend for a Riverside employee who is a State Wraparound Coach and Certified Trainer and $1,000 stipends to support 3 staff becoming certified coaches to support sustainability of training into future periods. We have budgeted $2,988 to cover payroll tax on these payments to staff.

We will use $531.50 to purchase 2 copies each of VVDB's The Foundations of High Fidelity Wraparound: The Wraparound Facilitator Textbook and the Family Support Partner Textbook and $156.30 for 2 copies of VVDB's Coaching High Fidelity Wraparound: The Wraparound Coach and Trainer Textbook. Each CSA already has a copy of VVDB's training DVD, High Fidelity Wraparound: Mariam's Family, which accompanies the workbooks. However, in order for 2 groups to train simultaneously, each CSA will need to purchase an additional set at a total cost of $1500. An additional $32 is set aside for any shipping costs attached to ordering the training materials.

We also have budgeted $4200 to enable a total of 3 program managers/supervisors chosen from each CSA to attend the annual Wraparound Initiative Implementation Academy Conference.

Years 2-5 Budget Workforce Development Investments: $116,678

In budget period 2 we plan to continue providing stipends for additional staff to complete Tier I and Tier II Wraparound Certifications as explained in budget period 1 above and have budgeted $24,955 for this use, including $23,000 in stipends and $1,955 in payroll taxes. In budget period 3 this amount is $4,000 for stipends and $342 in taxes. Budget 4 is $5,500 for stipends and $468 in taxes, and in budget period 5 they are $3,000 for stipends and $255 in taxes. We assume that by this time both CSAs will have all staff trained and certified.

Additionally in budget period 2, $8400 is budgeted for three program managers/supervisors from each CSA to attend the annual National Wraparound Initiative Implementation Academy Conference to strengthen our ability to support fidelity to the model. $5600 is budgeted to support one staff from each CSA to complete the UMASS intensive online Motivational Interviewing course. An additional $5,854 is budgeted in budget period 2 for other training purposes that may include Trauma Informed Care, Mindfulness, conflict resolution and/or Supervision techniques.

In budget period 3 $4,054 is budgeted for other training purposes as described, $7,000 is budgeted to enable a total of 5 program managers/supervisors chosen from each CSA to attend the annual Wraparound Initiative Implementation Academy Conference to strengthen our ability to support fidelity to the model, and $22,400 is budgeted to support 4 staff from each CSA to complete the UMASS intensive online Motivational Interviewing course.

In budget year 4, $1051 is budgeted for additional training as described and $7,000 is budgeted to enable a total of 5

program managers/supervisors chosen from each CSA to attend the annual Wraparound Initiative Implementation Academy Conference. Additionally, $11,200 is budgeted to support 2 staff from each CSA to complete the UMASS intensive online Motivational Interviewing course.

In budget year 5, $5,600 is budgeted for two program managers/supervisors from each CSA to attend the annual Wraparound Initiative Implementation Academy conference.

Operational Infrastructure **Total: $** 48,858

In the box below, please provide a description of all items within the Operational Infrastructure investment category (e.g. system change resources, performance management capabilities and additional operational support). Please be sure to specify the goals and project(s) this investment will support, as described in **Section 3.4** and **Section 6** of the RFR and document how these investments will assist in meeting the terms of the contract.

Prep Budget-Operational Infrastructure Investments: $2,900

Beginning in this period, $2,900 is dedicated to adding additional consultation from a child psychiatrist to work with both of Riverside's CSAs (currently at the rate of $100/hour and to be negotiated in future years). This consultation will be different from what our current psychiatry consultation entails. It will focus specifically on medical issues such as interactions between chronic medical conditions and psychiatric conditions, chronic pain management, eating disorders, and coaching and assisting staff to better coordinate with pediatricians and medical specialists etc. During this prep period, the psychiatrist will utilize some of the consultation time for meeting with managers for planning purposes for the ongoing program consultation. This consultation is in addition to and differs from the psychiatric medication consultation that already occurs at both CSAs.

Year 1 Budget-Operational Infrastructure Investments: $4,100

As noted above, $4,100 will be dedicated to consultation time from a child psychiatrist to focus on existing chronic medical conditions and how they my impact the mental health of clients and their families. This consultation will focus on the comorbidity of medical conditions and mental health disorders and how the team can support the family with issues of medication adjustments, compliance, etc. The consultant will also be able to answer specific questions related to these topics. Additionally, the consultant will support improved coordination with pediatricians and medical specialists by answering any specific questions that are related to the healthcare system. While staff will be trained in this area, having ongoing, in the moment support will be critical. This consultation is in addition to and differs from the psychiatric medication consultation that already occurs at both CSA's. Additionally, there will be an estimated 3% escalation per budget year reflected to cover potential increase in cost per hour in upcoming budget periods.

Years 2-5 Budget-Operational Infrastructure Investments:$36,858

The following amounts will be dedicated to consultation time from a child psychiatrist as described in budget year one. Each year includes a 3% escalation from previous budget period to reflect potential increase in cost per hour.
budget period 2, $7210
budget period 3, $7,426
budget period 4, $7,649
budget period 5, $7,878

Beginning in budget period 2 we intend to add a nurse/nutrition consultant to provide consultation for staff to learn more about the mind/body/nutrition connection and its relationship to mental health and chronic disease and how to talk to families about these issues when coordinating care. This is budgeted at $1,600 per year allowing for approximately two 2 hour consultations per quarter at each of our two CSAs. There will be an estimated 3% escalation per budget year reflected to cover potential increase in cost per hour in upcoming budget periods.

Technology **Total:** $232,398

In the box below, please provide a description of all line items within the Technology investment category (e.g. Health Information Technology and care management software, IT project management resources, data analytics capabilities, ICC

service delivery technology). Please specify the goals and project(s) this investment will support, as described in Section 3.4 and Section 6 of the RFR and explain how these investments will support the Contractor's performance of the Contract.

Prep Budget-Technology Investments: $156,092

$75,750 is budgeted for investment in computer equipment to allow us to supply 35 of our CSA employees in our two CSAs with state of the art mobile technology, equipped with our cloud-hosted EHR, MyEvolv from Netsmart Technologies or other software as may be determined. At approximately $2,150 per equipment set-up with currently available pricing, it will include a Dell Latitude E5470, Hotspot, antenna, signature pad, printer for printing in field sites, wireless keyboard and remote mouse, and carrying bag, as well as desktop monitors, docking stations, access to the MyEvolv EHR, access to a common networked shared drive and access to all standard Riverside employee related administrative applications.

We are budgeting a total of $80,342 in the prep budget period for IT project management to help us develop the ability to electronically exchange client information with other providers with whom the children/families are involved. This CSA project will be able to leverage external exchange capabilities with Massachusetts Accountable Care Organizations (ACO's) which is partially funded by Riverside's BHCP to establish data flows between Riverside and non-ACO providers involved with CSA families. The Prep Period funding will be spent on implementing care management software applicable to the CSA and/or developing electronic exchange with non-ACO based providers such as independent PCPs, other Behavioral Health agencies, and other key providers, and establishing the client consent methodologies required. Money will be spent creating MDMI links and managing their testing and implementation. $69,152 of this money will be dedicated to the cost of hiring a consultant and the cost of implementing these data exchange connections and/or care management software suitable for the CSA. The consultant will be responsible for building on work we expect to do to connect our proposed BH CP to the ACOs, and will focus on enabling our CSAs to electronically exchange data with non-ACO entities such as PCPs, other BH providers, etc. and to develop programming that will be uniquely required for the CSAs. We expect that some portion of this consultation funding may be subcontracted to MDIX, Inc. who are MDMI (Model Driven Message Interoperability open data exchange) experts. SAMHSA is leading a coordinated effort to deploy MDMI as part of their comprehensive Omnibus Care Coordination (OCC) package and Riverside is collaborating with SAMHSA to ensure that OCC meets the data exchange requirements of the BH community. Ultimately, this may be a lower cost means of electronically connecting between entities than is currently available through vendors. We expect that consultants will establish some initial "maps" between our CSAs and non-ACO entities and will begin to teach our IT Department how to do this so that we can eventually complete additions in-house. Additionally, $11,190 is budgeted for a portion of our CIO's salary. This includes 24 hours/month of his time to oversee project/consultant. Please note we plan to utilize partial funding available through our BHCP and partial funding available through the CSA to offset some of the costs of technology investments needed by both programs and it will not be duplicative.

Funds requested here will not duplicate funds we may receive from the BH CP.

Year 1 Budget-Technology Investments: $60,856

$48,350 is budgeted for investment in computer equipment to allow us to supply 35 of our CSA employees in our two CSAs with state of the art mobile technology, equipped with our cloud-hosted EHR, MyEvolv from Netsmart Technologies or another application. At approximately $2,150 per equipment set-up with currently available pricing, it will include a Dell Latitude E5470, Hotspot, antenna, signature pad, printer for printing in field sites, wireless keyboard and remote mouse, and carrying bag, as well as desktop monitors, docking stations, access to the MyEvolv EHR, access to a common networked shared drive and access to all standard Riverside employee related administrative applications. The equipment is expected to serve for a 7 year period before replacement is desired.

$9,506 is budgeted in this period to support adding MDMI exchange links to new providers that are engaged over time and/or for any modifications that may be required for the CSAs. This money will be utilized either with an external consultant or for additional internal IT staffing.

We intend to utilize $3,000 to equip each CSA with a monitor/web camera to enable use of Go To Meetings to facilitate

consultation/coaching as a group.

Years 2-5 Budget-Technology Investments: $18,450

In budget period 2 an additional $12,000 will be utilized again to continue to add new exchange links and/or for modifications as described above.

In budget period 4 we will use $6450 for additional laptops for staff.

Section 6.4 Proposed Projects and Investment Plan

A. Project Description

Project One, Information Technology

In order to create the technical infrastructure required to meet the project's stated goals, Riverside plans to spend the majority of the Preparation funding on building a sustainable data collection and exchange environment for our CSA programs. This includes spending for personal laptop computers for CSA personnel as well as on the design and implementation of comprehensive data exchange capability with non-Riverside personnel (ACOs, PCPs, and other external care providers). Please note that we have already made a substantial investment in an electronic health record which is being customized for the CSAs.

a. Computers for CSA personnel:

The investment in computer equipment will allow us to upgrade 54 of our CSA employees to state of the art computers. Each will be equipped to provide access to our cloud-hosted EHR, MyEvolv from Netsmart Technologies. While computer configurations will defer depending on employee function, the fully loaded configuration will consist of:

Dell Latitude E5470 (w/SSD)
Hotspot – for remote access where client-supplied networking is not available
Antenna - for remote access in areas with weak MiFi coverage
Signature pad with eSignature software, for client signature capture on consent forms, etc.
HP LaserJet Pro MFP M225dw Printer for printing in field sites
Wireless keyboard & remote mouse
Carrying Bag
Desktop Monitor and Docking station for office production
Standard riverside OS, including secure remote desktop
Access to the Evolv EHR
Access to a common networked shared drive.
Access to all standard Riverside employee related administration applications.

Our plan is to purchase and deploy 35 devices during the Preparation period of this project and 19 in Budget period 1 (original plan had all devices being purchased in Prep Period). Purchase, configuration, training, and deployment of the computer equipment will be managed by Eamon McDaniel, Riverside's IT Technical Services Manager. Each device will have a 5-year warranty.

At the end of Project one, all staff from both CSA's will be fully equipped with updated technology necessary to manage workflows. Using these devices, Riverside CSA personnel will be able to perform all of the tasks required to achieve the other stated goals of this initiative.

b. Data Exchange Infrastructure:

The electronic exchange of client records and information is a critical element in reaching our stated goals. As evidenced by providers across the country, this is not an easy task to achieve. Riverside is currently working with SAMHSA and external vendors to implement a comprehensive data exchange capability across Riverside, based upon new technology.

Our approach will utilize the Object Management Group's (OMG) recent Model Driven Message Interoperability (MDMI) open data exchange standard. OMG is an independent open standards group with a 40+ year track record of successful technical innovations. MDMI is an open standard aimed at facilitating abstracted electronic data sharing between disparate entities within any common industry. SAMHSA is leading a coordinated effort to deploy MDMI as part of their comprehensive Omnibus Care Coordination (OCC) package. Riverside is collaborating with SAMHSA to ensure that OCC meets the data exchange requirements of the behavioral health community. Building on the work we expect to do to connect our proposed BH CP to the ACO's, we will focus on enabling our CSA's to electronically exchange data with non-ACO entities such as PCPs, other BH providers, etc… and to develop programming that will be uniquely required for the CSA's. The Preparation funding allocated for integration will be spent developing theses electronic exchanges and establishing the client consent methodologies required. The money will be spent creating MDMI links and managing their testing and implementation. (no change from intent of original plan- clarification only) In all of these exchanges, Riverside will establish the ability to translate the data formats provided by the ACO and other providers into a format that can be absorbed within Riverside's Evolv EHR. Appropriate client consents will be stored within Evolv, and will dictate the extent to which CSA personnel send or receive client information.

The electronic exchange component of this initiative will be managed by Charles O'Neill, Riverside's Chief Information Officer. We will also subcontract some of this effort to MDIX, Inc. who are MDMI experts.

Subsequent IT spending in Budget period 1 and Budget Period 2 will be spent adding MDMI exchange links to new providers that are engaged over time.

The implementing of care management software and establishing exchange connections is critical in providing high fidelity wraparound services and allows for strong integration with ACO's, primary care providers and other providers for ICC -engaged members. By the end of project one, our two CSA programs will be operating within an electronic care management solution, either Evolv or Care Navigator, that will more adequately capture provided services. These updates will have significantly improved our ability to communicate electronically with ACO's and other providers involved with enrolled families.

Project 2, High Fidelity Wraparound (Workforce Development)

Beginning in Budget period One, Riverside Community Care will utilize DSRIP funding to strengthen our commitment to providing every CSA enrolled youth and family with High Fidelity Wraparound. Since the inception of our CSA programs, we have placed a strong emphasis on program development, training and supervision to support the goals of Wraparound, and we are excited to use this opportunity to both enhance and create sustainability in our practice. Specifically, funding will be used to create a training framework that will incentivize all CSA staff to become Wraparound Certified using the Vroon Vandenberg curriculum, spanning budget periods in decreasing amounts.

We will utilize funding to directly impact our practice of High Fidelity Wraparound by utilizing one of our existing managers to provide training and certifications across both of our CSA sites. Joanne Flatley is our Assistant Program Director at our Needham location, who first began working at the program in 2009 as a Family Partner. Joanne has been a Statewide Family Partner coach for the past 4 years and is Coach Certified for Family Partners, Coach Certified for Wraparound Facilitators and is also Wrap Process Mentor Trained. In Budget Period One Joanne will certify two Coaches in Somerville and one additional Coach in Needham. These coaches will be in supervisory roles in both programs, and their certification will enhance their ability to train, supervise and oversee the Intensive Care Coordinators and Family Partners. Having leadership of each site deepen their High Fidelity Wraparound skill sets will have a direct impact on the quality of services provided to each youth and family. It takes approximately 6 months for a Coach to complete this certification process once they have completed Tier One and Tier Two Certifications (an additional 32 hours). We will compensate Joanne for the additional work hours put towards certifying these three coaches with a one-time stipend. With four Coaches in place across the agency, we will ensure sustainability in our effort to certify all existing and incoming ICC and FP staff. Having more than one per site will also account for potential turnover in our supervisory team.

Riverside will utilize funding to provide monetary incentives for ICCs and Family Partners to enhance their individual skills by becoming Tier One and Tier Two certified. From the beginning of the implementation of CSA programs and training provided, obtaining Wraparound Certification was encouraged but not mandated across the state. From the Vroon Vandenberg Website: "Wraparound Certification is one component of the Vroon VDB Wraparound Coaching and Certification system (WCC), a multi-method approach to training, coaching, and assessing the quality of wraparound process planning and implementation for children and youth with complex needs and their families. The WCC includes separate certification processes for wraparound facilitators, family and youth support partners, wraparound coaches for wraparound facilitators, wraparound coaches for family support partners, wraparound supervisors, wraparound trainers and wraparound process mentors. The Certification system is a performance based monitoring process that evaluates the wraparound staff's ability to provide and document high fidelity wraparound. The WCC is a performance-based system in which each wraparound staff function is defined in a series of action steps. The action steps are the foundation for communicating job expectations for initial training and ongoing coaching for each staff function. The action steps have been organized into certification tools that are used to monitor performance. These tools are used during initial training and coaching to communicate expectations, provide ongoing feedback and establish a threshold for being certified as a wraparound staff practitioner. Once the wraparound staff has demonstrated competency through these certification reviews, ongoing fidelity is monitored with the Vroon VDB wraparound fidelity tools." We will funding to purchase Vroon VDB training materials including two copies each of VVDB's The Foundations of High Fidelity Wraparound: The Wraparound Facilitator Textbook and the Family Support Partner Textbook and two copies of VVDB's Coaching High Fidelity Wraparound: The Wraparound Coach and Trainer Textbook. Each CSA already has a copy of VVDB's training DVD, High Fidelity Wraparound: Mariam's Family, which

accompanies the workbooks. However, in order for 2 groups to train simultaneously, each CSA will need to purchase an additional set. (purchase of training materials not in original plan).

At one time, in our Needham program, we had 3 Leadership staff who were trained as Coaches, and had implemented Tier One Certification into the training for all new hires, which happens in the first 2-4 weeks of employment. We have been able to continue the practice of having new staff Tier One certified and currently have twenty four staff in Needham who have completed the Certification. We will use funding to incentivize them for this training and to complete additional training. With Coaches trained in Somerville, we would implement the same training for all staff, both current and then new staff as hired.

We would then add the expectation of staff working towards Tier Two Certification, with an additional incentive awarded at the time of completion. Tier Two coaching/certification is completed by working with families under close supervision until the wraparound staff demonstrates competencies in the components of wraparound. This is completed through a mix of observation, demonstration and writing. It starts with a Learning Style inventory of the staff member. Family Partner skills are observed thru two intakes, two Strength Need Culture Discovery meetings, two care plan meetings, one agenda prep and two home visits. Documents are completed around Self- efficacy, Natural Supports and "Do For, Do with and Cheer On" theories (typically focused on the same families as the observations). Finally a document review of the two family's wraparound documentation and an evaluation by supervisor.

The ICC skills are observed in much the same way- two intakes, two care plan meetings, one assessment, one agenda prep, one debrief, one crisis planning meeting. Written documentation reviewed are FBA, safety plan, care plan documents, transition plan as well as documents on Self Efficacy, Working with a Team Member and Working with families on strengthening natural supports. Vroon VVB has identified specific skills for each role (102 for FPs, 105 for ICCs), all of which should be observed within the process of completing the Tier Two Certification.

In addition, in Budget Periods 1, 2, 3, 4 and 5 we will utilize funding to send supervisors/managers (clarification on staff and would like to send staff for all budget periods rather than just 3) from each site and one senior leader to the National Wraparound Implementation (NWI) Academy, a once yearly conference put on by the National Wraparound Initiative .Participants share learning opportunities with the field's foremost experts in Wraparound and systems of care. This opportunity helps management keep a pulse on Wraparound trends/ networking events/ trainings, etc., and has been incredibly informative and valuable for Joanne Flatley, who attended last year and will attend again in September.

The measurable outcome of this project is the improved delivery of High Fidelity Wraparound in our ICC and FS&T services to youth and families. This will be measured through the TOM and WFI quality measures in place, as well as in weekly supervision and Riverside's annual internal performance evaluation process and Client Satisfaction Survey process. Improving quality of services delivered will also improve timely access to ICC services. Enhancing the skill sets of staff directly impact transition planning, safety planning and team coordination, all of which could result in sustainable change and a more timely discharge from services, thus allowing the enrollment of other youth and families.

This project will be implemented by the Allison Clark, LICSW, Program Director our Cambridge/Somerville program and Meritt Smith, LICSW, Program Director of our Needham program, who will monitor progress towards goals. Kim Conley, LMFT, Assistant Vice President of Child and Family Services is the direct supervisor of both Program Directors and will support their implementation and ensure project completion. Kim will review all outcome data collected with Program Directors and report results to Shannon Sorensen, LICSW, Vice President of Child and Family Services.

Project 3, Training and Consultation (Workforce Development)

Riverside will utilize DSRIP funding to directly train our CSA workforce in both of our sites. Specifically, we will train in the following areas: (highlighted below are added/changed trainings)

- Pediatric medical conditions and chronic disease management
- Improving Wraparound Supervisor skill sets
- Trauma Informed Care
- Motivational Interviewing
- Nutrition/Wellness/Mind body connection
- Mindfulness
- Conflict Management- How to have Difficult Conversations

Throughout the five budget periods, we will ensure that funding goes directly to impacting the knowledge and skills needed for our staff to be prepared to provide the highest quality of services and stay current with changing ACO climate. This will be accomplished through consultation, internal and external trainings.

A key facet of fostering strong integrations with ACO's and Primary Care Providers is to understand how the medical system works and how chronic medicals conditions impact mental health. Our intent is to use funding throughout the Prep and five budget periods to increase access for both of our teams to Tyrone Williams, M.D., Child and Adolescent Psychiatrist, who has served as our psychiatric consultant for our CSA program in Somerville since the opening of the program. Dr. Williams is a natural choice to consult to our teams in this subject as he has an excellent working knowledge of the CSA services, and the roles our ICCs and FPs play in the delivery of High Fidelity Wraparound. Dr. Williams is a consultant to us through the Cambridge Health Alliance (CHA), where he is employed in their Child and Adolescent Psychiatry Department. Housed within the greater CHA hospital system, Dr. Williams has a unique perspective on how psychiatry and medical care are integrated in treating the whole child and family. He has direct access to an array of PCPs within the hospital system, many of whom work with our enrolled youth in Somerville. Our plan would be to increase his time in Somerville, and add time to Needham, to consult to staff. Increased hours would allow Dr. Williams consultation time with program leadership around needs of each team. His consultation time with teams would be in addition to the psychiatry consultation time that currently exists in both programs, and focus specifically on the comorbidity of medical conditions and mental health disorders and how the team can support the family with issues of medication adjustments, compliance, etc.…It would also focus on issues such as interactions between chronic medical conditions and psychiatric conditions, chronic pain management, eating disorders, etc.… Dr. Williams will also

be able to answer specific questions related to these topics. Additionally, he will be able to support improved coordination with pediatricians and medical specialists by answering any specific questions that are related to the healthcare system. While staff will be trained in this area, having ongoing, in the moment support will be critical. This consultation is in addition to and differs from the psychiatric medication consultation that already occurs at both CSA's After project year 5 we believe that staff will have developed adequate skills in these areas and we would no longer need additional, separate consultation. We would be able to incorporate these topic areas into the existing time for psychiatry training and consultation. (highlights provide clarification regarding role of psychiatric consulted as requested).

In order to facilitate these consultations, we have included the purchase of equipment to allow for the flexibility of "meeting" remotely. We will purchase a large Monitor (initial plan indicated a TV) for both sites, equipped with a camera, so that Dr. Williams, or other consultants, could video conference into a site other than where they are located. This will allow greater access for the whole team to consultants without losing the time of driving which increasingly makes for more efficient use of everyone's time.

To enhance our team's understanding of how to support both medical and mental health needs of our youth, we intend to use funding to hire outside consultants in a variety of health and wellness fields. Our goal would be to have a quarterly training/consultation period for each team with experts in our communities that could inform our staff of best practices in the fields of nutrition, nursing, mindfulness, child development, alternative healings, yoga etc. As each of our sites varies in the unique populations of families we serve, we envision being flexible in finding experts who meet the needs of the youth we have enrolled. Utilizing experts in our communities will help ensure ongoing resources are available for both our staff and our families, who may benefit from directly accessing services as appropriate and available. We would expand our Systems of Care to include these community professionals as appropriate as well.

It has long been known that exposure to trauma in childhood negatively impacts both mental and physical health, with far reaching impacts into adulthood. We believe that providing best practices in Trauma Informed Care across our entire system delivery improves the experience and the outcomes of our services. We will utilize funding to ensure CSA staff have access to ongoing best practices in the field of trauma. This will include trainings and consultation provided by our Riverside Trauma Center, as well as external trainings in the community and online resources such as Relias Learning. Riverside is committed to enhancing our online training as a way to offer flexible trainings to reach more staff who are hindered by geography or time constraints in their schedules.

At project end, staff at both CSA sites will be equipped with the skills necessary to be able to identify and support both the medical and mental health needs of youth served. They will have gained skills around conflict management, how to implement mindfulness activities with families, and how nutrition relates to overall health. Additionally, staff will have enhanced knowledge of relevant topics such as of how trauma impacts the medical and mental health of youth.

Additionally, we will use funding to train staff in Motivational Interviewing; a best practice which can be used by both ICC's and FP's to help motivate lasting change in our clients. This evidence-based model aligns well with the Wraparound model. As we know, research has

demonstrated that motivational interviewing can improve client engagement, help to resolve client ambivalence, and promote client involvement in activities that lead to better health outcomes. At the end of this project, our staff will be trained in this practice, enhancing their work with families served. They will use gained knowledge in this model to help families identify areas of need and to brainstorm options to meet identified goals. In budget year 2 we would fund one supervisor per site to complete the "Evidence-Based Program to Build MI Knowledge and Skills" program offered through UMASS Medical School which is designed for individuals in health care fields. We would be able to fund 3 additional staff per site in Budget Period 3. The Certificate of Intensive Training in Motivational Interviewing is a semester-long course that is founded on the principles detailed in Miller & Rollnicks, *Motivational Interviewing, 3rd ed.* These eight staff would bring this knowledge back to the program and help infuse these techniques into training for all employees. The principles of MI can be used with people of all ages, so would benefit the work done with youth as well as their families.

All DSRIP funding used to fund this project would directly improve the quality of work provided to our clients. Offering the opportunity to increase their knowledge and skills improves staff satisfaction and positively impacts staff retention. As the job market in the Commonwealth has improved overall, the mental health system has collectively been impacted as hiring as become more difficult and more much competitive. As a result, the trend is to hire less experienced clinical staff who often need significantly more training and supervision than in years past. An investment in their skill building directly impacts the quality of care provided and a decrease in turnover means less disruptions in services for families. For Family Partners, many have never worked in the human service field prior to their employment at the CSA, so many of these trainings are critical for their job development. In addition, Family Partners have fewer career advancement opportunities, so providing ongoing training and skill building is essential for our many employees who have worked in this role for many years. Outcomes will be measured in ongoing Client Satisfaction Surveys and with Discharge outcome data that is analyzed by our Quality Management Department. As well, we will use Employee Engagement Survey results to gauge employee satisfaction as well as Performance Evaluation tools to monitor career advancement goals.

This project will be implemented by the Allison Clark, LICSW, Program Director our Cambridge/Somerville program and Meritt Smith, LICSW, Program Director of our Needham program, who will monitor progress towards goals. Kim Conley, LMFT, Assistant Vice President of Child and Family Services is the direct supervisor of both Program Directors and will support their implementation and ensure project completion. Kim will review all outcome data collected with Program Directors and report results to Shannon Sorensen, LICSW, Vice President of Child and Family Services.

B. Project Team Description

Project One, Information Technology

Chief Information Officer – Charley O'Neill

- Responsible for overseeing all of the activities of the Technology Services Manager and the Director of Integration Services under this proposal

- Responsible for business level relationships with all non-Riverside partner providers (ACOs, PCPs, etc.).
- Responsible for adhering to all HIPAA requirements in the use and exchange of client records.
- Responsible for the budgeting, spending, and tracking of all IT spending under this proposal.
- 35 years experience developing Enterprise Application Systems, as both user and vendor (Prime, FireStar, Semantx)
- 9 years direct involvement in the development and deployment of the MDMI data exchange Standard.
- Proven ability to build solutions based upon emerging technologies

Technology Services Manager – Eamon McDaniel

- Responsible for the definition of all computer equipment under this proposal.
- Responsible for the timely purchase and configuration of all computer equipment.
- Responsible for end-user IT training associated with the new computer equipment.
- 20 years experience managing Information Technology functions and assets (IBM, Lotus, others).
- Proven ability to ensure that technology architecture, capacity, availability, and resources are aligned with the strategic directives.
- Proven ability to oversee information technology policies, procedures, processes and operations to provide maximum value for the organization.
- Proven capacity to ensure that Information Technology assets promote effective and efficient operations

Director of Integration Services – TBD

- Half-time position – directly funded by monies budgeted within this proposal
- Responsible for the coordination of the technology integration work effort performed by SAMHSA and MDIX (SAMHSA subcontractor), as that work effort is leveraged under this proposal. Note, as stated elsewhere, the SAMHSA and MDIX work is <u>not</u> funded as part of this proposal, but that work is used to leverage the goals set herein.
- Responsible for the detailed formulation of electronic message exchange between Riverside and all non-Riverside provider partners under this proposal.
- 5 years+ experience with the MDMI data exchange Standard and various implementations.
- Proven extensive Program and Project management skills
- Proven comprehensive quality assurance and testing skills.

Projects 2 and 3, High Fidelity Wraparound and Training/Consultation

Vice President of Child and Family Services- Shannon Sorensen, LICSW

- Senior Leader of the Division who will be responsible for the oversight of overall implementation of both projects through the supervision of Kim Conley, AVP
- 18 years clinical and managerial experience with youth and families

- Four years of Senior Leadership experience at Riverside Community Care
- Started at Riverside as the Program Director for the CSA in Needham at the start-up of the program in 2009, was in that role for four years; trained and supervised ICC's and FP's.
- Trained by Vroon Vandenberg, Certified Wraparound Facilitator
- Trained in Psychological First Aid, responder for the Riverside Trauma Center

Assistant Vice President of Child and Family Services, Kim Conley, LMFT

- Senior Leader of the Division who will be responsible for the oversight of overall implementation of both projects through the supervision of Allison Clark and Meritt Smith, Program Directors of the CSA programs
- Has worked at Riverside in the CSA at the start-up of the program in 2009, including as a Senior ICC and then as the Program Director for 3 years; trained and supervised ICC's and FP's.
- Trained by Vroon Vandenberg, Certified Wraparound Facilitator
- Trained in Psychological First Aid, responder for the Riverside Trauma Center
- CHA/Harvard Medical School Teaching Faculty for four years.

Program Director, Somerville CSA- Allison Clark, LICSW

- Leader of the CSA Program with direct responsibility for overseeing training, supervision and evaluation of all employees.
- Will be responsible for ensuring certifications, trainings and consultations are arranged and completed.
- Will ensure outcome data is collected, analyzed and used to modify practice
- CSA Program Director and CHA/Harvard Medical School teaching faculty for one year, was the Senior ICC prior to promotion into current role.
- Completed the Ackerman Institute for the Family "Foundations in Family Therapy" core training program and the Dr. Kenneth Hardy reflective supervision certification course.

Program Director, Needham CSA-Meritt Smith, LICSW

- Leader of the CSA Program with direct responsibility for overseeing training, supervision and evaluation of all employees.
- Will be responsible for ensuring certifications, trainings and consultations are arranged and completed.
- Will ensure outcome data is collected, analyzed and used to modify practice
- CSA Program Director for one year was the Senior ICC prior to promotion into current role.
- High Fidelity Wraparound Training- Tier I certified, Tier II eligible
- Completed Multicultural Supervision Group with Dr. Ken Hardy

Assistant Program Director, Needham-Joanne Flatley

- Will oversee Wraparound Certification for both sites, including direct training of 3 Coaches to ensure sustainability and ongoing coaching expertise, and Tier 2 training in

Budget period one

- Tier 1 and Tier 2 Family Partner Certification
- Tier 1 and Tier 2 Wraparound Facilitator Certification
- Coach Certified for Family Partner
- Coach Certified for Wraparound Facilitator
- Wrap Process Mentor Trained
- Statewide Family Partner coach for the past 4 years, responsible for running a Learning Collaborative on High Fidelity Transition, Southeast Regional meetings and Senior Family Partner Leadership forums bi-monthly each year. Individual CSA coaching with numerous CSAs around Theory of Change, Support Systems, The Parent Journey and Preventing Drift. Presented yearly at one of the Statewide Meetings a relevant topic to the management teams from all CSAs.

C. Implementation Plan and Timeline

Project One, IT

Preparation Budget Period:

Month one:

- Order Equipment
- Identify specific CSA message types and data content requirement

Month two:

- Stage and configure equipment
- Apply CSA message types to ACO exchange infrastructure

Month three:

Deploy equipment and train users

- Extend exchange infrastructure to non-ACO based providers

Month four:

- Extend exchange infrastructure to non-ACO based providers

Month five:

- Extend exchange infrastructure to non-ACO based providers

Budget Period One:

Quarter one: Order and deploy equipment, Extend exchange infrastructure to non-ACO based providers (per indicated plan revision).

Quarter two: Extend exchange infrastructure to non-ACO based providers

Quarter three: Extend exchange infrastructure to non-ACO based providers

Budget Period Two:

Quarter one: Extend exchange infrastructure to non-ACO based providers

Quarter two: Extend exchange infrastructure to non-ACO based providers

Quarter three: Extend exchange infrastructure to non-ACO based providers

Quarter four: Extend exchange infrastructure to non-ACO based providers

Project Two, High Fidelity Wraparound

Budget Period One:

Quarter one: Programs identify the 3 staff who will be trained as certified Wraparound Coaches. Joanne Flatley, Assistant Program Director, begins the training, which will take roughly 6 months to complete.

Quarter two: Training of 3 Coaches continues. Tier One Coaching and Certification begins and incentives granted as completed.

Quarter three: Training of 3 Coaches is completed. Tier One Coaching is completed and Tier Two Coaching is implemented. Incentives granted as completed.

Staff attends National Wraparound Initiative Implementation Academy (per indicated plan revision- added in all budget periods).

Budget Period Two:

Quarter one: Tier One Coaching continues; Tier Two Coaching begins for the employees who completed Tier One certification in Budget Period One.

Quarter two: Tier Two coaching continues.

Quarter three: Tier Two Coaching continues.

Quarter four: Tier Two Coaching is completed and incentives granted.

Staff attends National Wraparound Initiative Implementation Academy

Budget Period Three:

Quarter one-four: Tier One and Tier Two Coaching is completed for all new employees hired and incentives granted. Send one manager from each Program to the National Wraparound conference.

Quarter four: Staff attends National Wraparound Initiative Implementation Academy

Budget Period Four:

Quarters one-four: Tier One and Tier Two Coaching is completed for all new employees hired and incentives granted.

Budget Period Five:

Quarters one-four: Tier One and Tier Two Coaching are completed for all new employees hired and incentives granted.

Quarter four: Staff attends National Wraparound Initiative Implementation Academy

Budget Period Five:

Quarters one-four: Tier One and Tier Two Coaching is completed for all new employees hired and incentives granted

Quarter four: Staff attends National Wraparound Initiative Implementation Academy

Project Three, Training and Consultation

Preparation Budget Period: (Clarification-Dr. Williams will not be providing training on integration with ACO's and Primary Care Physicians as outlined in original proposal. Adjustments are highlighted in Project Three summary and any reference to him providing training is removed from below implementation timeline).

Month one: Vice President, Assistant Vice President, Program Directors and Tyrone Williams, MD meet to assess needs and formulate plan for how consultation will be implemented in each program to meet the identified goals.

Month Two: Dr. Williams will prepare and schedule first consultation time with each program.

Month Three: Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.

Month Three: Dr. Williams will meet with each program and provide consultation tailored to the needs of each program

Month Four: Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.

Month Five: Dr. Williams will meet with each program and provide consultation tailored to the needs of each program. Dr. Williams will meet with each Program Director and Assistant Vice President to assess progress towards identified goals.

Budget Period One:

Quarter one: Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.

Quarter two: Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.

Quarter three: Dr. Williams will meet with each program and provide consultation tailored to the needs of each program. Dr. Williams will meet with each Program Director and Assistant Vice President to assess progress towards identified goals.

Budget Period Two:

Quarter one:

- Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.
- One large Monitor and web camera per site will be purchased, configured and set up (this equipment will not be purchased in Budget Period one).
- Kim Conley will meet with each Program director to assess specialty consultation needs; feedback will be gathered from teams.
- Kim Conley and Program Directors will locate and hire consultants.
- Consultations will be set up at each site (to occur quarterly).
- Identify one supervisor per program to attend Motivational Interviewing Course; enroll in program.
- Program Directors identify relevant trainings for staff (Trauma Informed Care, mindfulness, etc...) and enroll employees as appropriate.

Quarter two:

- Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.
- Consultations will occur in each program.
- Staff attend identified trainings

Quarter three:

- Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.
- Consultations will occur in each program.
- Staff attend identified trainings

Quarter four:

- Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.
- Dr. Williams will meet with each Program Director and Assistant Vice President to assess progress towards identified goals.
- Consultations will occur in each program.
- Staff attend identified trainings

Budget Period Three:

Quarter one:

- Kim Conley will meet with each Program director to assess specialty consultation needs; feedback will be gathered from teams.
- Kim Conley and Program Directors will locate and hire consultants.
- Consultations will be set up at each site (to occur quarterly).
- Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.
- Identify four (added additional 2) staff per program to attend Motivational Interviewing Course; enroll in program.
- Program Directors identify relevant trainings for staff (Trauma Informed Care Etc.) and enroll employees as appropriate.

Quarter two:

- Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.
- Consultations will occur in each program.
- Staff attend identified trainings.

Quarter three:

- Dr. Williams will meet with each program and provide consultation tailored to the needs of each program
- Consultations will occur in each program.
- Staff attend identified trainings.

Quarter four:

- Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.
- Dr. Williams will meet with each Program Director and Assistant Vice President to assess progress towards identified goals.
- Consultations will occur in each program.
- Staff attend identified trainings.

Budget Period Four:

Quarter one:

- Kim Conley will meet with each Program director to assess specialty consultation needs; feedback will be gathered from teams.
- Kim Conley and Program Directors will locate and hire consultants.
- Consultations will be set up at each site (to occur quarterly).
- Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.
- Identify two staff per program to attend Motivational Interviewing Course; enroll in program.(added staff)
- Program Directors identify relevant trainings for staff (Trauma Informed Care Etc.) and enroll employees as appropriate.

Quarter two:

- Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.
- Consultations will occur in each program.
- Staff attend identified trainings.

Quarter three:

- Dr. Williams will meet with each program and provide consultation tailored to the needs of each program
- Consultations will occur in each program.
- Staff attend identified trainings.

Quarter four:

- Dr. Williams will meet with each program and provide training and consultation tailored to the needs of each program.
- Dr. Williams will meet with each Program Director and Assistant Vice President to assess progress towards identified goals.
- Consultations will occur in each program.
- Staff attend identified trainings.

Budget Period Five:

Quarter one:

- Kim Conley will meet with each Program director to assess specialty consultation needs; feedback will be gathered from teams.
- Kim Conley and Program Directors will locate and hire consultants.
- Consultations will be set up at each site (to occur quarterly).
- Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.
- Identify two staff per program to attend Motivational Interviewing Course; enroll in program.
- Program Directors identify relevant trainings for staff (Trauma Informed Care Etc.) and enroll employees as appropriate.

Quarter two:

- Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.
- Consultations will occur in each program.
- Staff attend identified trainings.

Quarter three:

- Dr. Williams will meet with each program and provide consultation tailored to the needs of each program
- Consultations will occur in each program.
- Staff attend identified trainings.

Quarter four:

- Dr. Williams will meet with each program and provide consultation tailored to the needs of each program.
- Dr. Williams will meet with each Program Director and Assistant Vice President to assess progress towards identified goals.
- Consultations will occur in each program.
- Staff attend identified trainings.

Budget Report and Budget Narrative (see Attachments B and C)

D. Sustainability

Our plan has been designed with structures in place to allow for the sustainability of each project. For IT, each device purchased will have a 5-year warranty. The equipment is expected to serve for a 7 year period before replacement is desired. We have existing infrastructure in place to repair and replace hardware as needed.

We hope, over the span of this funded period, to have added MDMI exchange links to the majority of providers that are connected with the youth we serve. We will be able to sustain these linkages through infrastructure built over this time period.

As described above, our plan to certify 3 managers across the Riverside as Coaches, in addition to the existing Coach we have, will allow us to maintain our ability to certify staff in both programs. Over the course of this funding, we will have been able to use funds to incentivize the large majority of staff, including new hires. Following this time period, we will be able to absorb the incentive payments into our ongoing budgets as the numbers will be limited only to turnover each year.

Training and consultation over the period of funding will allow the programs to build skills and knowledge that can inform and be carried forward. As specific knowledge is gained, it will become the foundation that will be used going forward for new and incoming staff. Supervisors will train new staff and resource libraries will be created to house all materials gathered to ensure sustainability.

Section 6.2: Executive Summary *(3 pages)*

A. Current performance on Development Plan

CSR CSA's Development Plan goals are focused on three main areas:

- **Comprehensive Assessments**: Comprehensive Assessments need more detail. Due to the constant shortage of clinicians and clinical supervisors and the high demand for services, the CSA struggles to ensure that documented Comprehensive Assessments are as thorough as they need to be. The CSA has retooled and intensified training and supervision related to comprehensive assessments, progress in this area is under regular monitor and review.
- **Safety Plans**: Better recognition for and utilization of safety plans; specifically supporting families in developing safety plans with specified action steps. Increased training and supervision have led to significant progress in this area; management reports reveal more than 70% of safety plans are being reviewed monthly with families and updated when circumstances change or crises arise.
- **Role Maintenance:** Avoiding role confusion and ensuring clarity in role specifications. Due to inexperienced field staff and/or large wraparound teams serving complex family needs, role clarity may be impacted. The CSR CSA Senior Team addressed concerns during department staff meetings resulting in the development of a supplemental document to aid staff in identifying "grey areas" and role overlap.
- **Although not in our Development Plan,** CSR CSA has its own goal to improve its WFI score in team member participation at care planning team meetings.

All these goals will be supported by projects described in this proposal.

B. Specific Strengths and Needs

<u>Infrastructure and Capacity to Monitor Quality</u>

Need - Limited Capacity to Generate Reports to Monitor Quality: Although the CSA's data systems have improved since Credible Electronic Health Records were installed in 2016, senior management still struggle to efficiently generate reports needed to monitor quality and support performance improvement efforts. CSR has not had the resources to purchase a supplemental EHR Reporting Software module. Reporting is cumbersome and managers waste precious time exporting data into spread sheets, limiting the range of metrics that can realistically be monitored.

Need - Staff Technology Challenges: While CSA staff all received basic training and extensive coaching on EHR, many staff need advanced training to increase speed, efficiency, improve data collection and increase understanding of performance improvement goals. 2 out of 3 CSA staff members reported that they would benefit from additional EHR training in a recent survey.

Strength - Successful Recent Implementation of EHR: CSR Behavioral Health's successful implementation of the Credible EHR in 2015-2016 is an excellent foundation for performance improvement efforts. It was an enormous transformational undertaking for a small organization. The unusually smooth implementation can be credited to the meticulous planning on the part of a skilled MIS/IT Coordinator and an active Behavioral Health EHR Implementation

Team who met weekly for over a year. The team continues to meet twice a month to guide EHR improvements and related staff training.
Strength - Data-Focused, Learning Organization: CSR's Behavioral Health Department is an active, learning organization whose senior leadership is energized by their new EHR system's capacity to generate data and support management systems.

Pediatric Partnerships & CSA Capacity for Health Care integration:
Need - Relationships with Pediatric Providers: The CSA needs to strengthen its focus on pediatric/behavioral health integration, develop strong partnerships with interested pediatric providers and expand access to ICC referrals from pediatric practices and hospitals.
Need - Health/Behavioral Health Integration Practice Protocols and Data Elements: The CSA needs to develop protocols and supervisor capacity to support health/behavioral health integration around prevention and wellness, avoidable utilization, follow-up after mental illness hospitalization, and strengthened care coordination. The CSA needs to develop protocols for communicating with pediatricians, including using the Mass Hi-way to support written information-sharing. The CSA needs to identify new EHR data elements that allow management to monitor practice change.
Need - Training & Coaching Needs: The CSA needs to train and coach CSA staff on the motives, the expectations and the benefits for delivering integrated care, including reinforcement of understanding in the ways in which chronic conditions such as asthma, diabetes and obesity are known to exacerbate mental health conditions. Additionally, staff require training in best practices for communicating with pediatricians.
Strength - Culturally Attuned, Responsive and Trusted Staff: CSR staff comes largely from the same communities as the families served, supporting culturally attuned and responsive care to families with a wide array of beliefs, cultures, languages and experiences. ACOs and pediatric providers may view this as a significant asset in considering partnering with CSR CSA.
Strength - Collaborative, Relationship-building Expertise: CSR Behavioral Health Department's experience at developing partnerships with the Boston Public Schools (described below), among other care providers and organizations, will inform relationship-building plans for strengthening collaboration, integration and referrals.

Pipeline of Licensed Masters-level Clinicians:
Need - Severe shortage of CSR clinicians for both ICC and IHT: The shortage of Masters level clinicians in Boston is more severe in home-based behavioral health services and felt most acutely in Greater Boston neighborhoods, where safety concerns, real and perceived, deter many clinicians. The CSR CSA has compensated for this shortage of MA-level clinicians by hiring a proportionately high number of BA-level ICCs. While many of these BA-level ICCs have years of experience providing care coordination, the staffing pattern places a disproportionate burden on CSA supervisors to conduct ICC clinical assessments which detracts from supervisor time focused on clinical supervision and coaching of ICCs. CSR's IHT service remains much smaller than desired by either CSR or the MCEs, and are marked by significant wait lists.
Need - Severe shortage of licensed clinicians to take on supervisory roles: The shortage of licensed supervisors adds to CSR CSA's workforce challenges. A disproportionately high number of experienced, practicing CSR clinicians have not taken their licensure exam, due to test-taking

anxiety possessed by many clinicians of color related to concerns regarding cultural bias of the licensure exam questions. Additionally, the CSA has a specific shortage of LICSWs, the only licensure able to provide supervision hours for all types of licensure. Our CSA Director is our only LICSW. This creates unique challenges in attracting new CSWs seeking clinical supervision.
Strength - Clinical Pipeline Planning and Pilot Project: In FY 2016, CSR Behavioral Health launched a planning process to design a formal clinical internship program. Previous informal efforts did not gain traction due to the added burden to a small cadre of overextended, licensed clinical supervisors at CSR. Consultant Yolanda Cuentro (former Director of IHT & Internship Program for The Home) worked with CSR Behavioral Health Senior Team to identify all the elements for a successful Clinical Internship program. An internship pilot was launched in FY 2017 and "Lessons Learned" inform our proposed design for the Clinical Pipeline project.
Strength - Interest from university Clinical Masters programs, including Social Work programs in a CSR Partnership: Thirteen clinical programs committed to partner with CSR CSA in 2018 to launch ongoing internship relationships.

C. Plans for improving timely access to ICC Services
Current BPS Partnership: CSR CSA's partnerships with 17 Boston Public Schools in Greater Roxbury continues to improve timely access to ICC Services. Our School-Based Program is a free service to BPS to increase access to CBHI services. School-based Coordinators provide support to Administrative Teams in identifying children in need of ICC and other CBHI services, and support to teachers in developing classroom strategies for youth with behavioral health needs. The program also runs a free Parent Café that rotates from school to school, providing information on children's behavioral health services to parents. The program also places Outpatient Clinicians in each school for individual counseling and groups.
Two Proposed Projects will improve timely access to ICC services**. Project 2, Pediatric Partnerships**, the CSA will actively reach out to engage pediatric providers most frequently serving our ICC-engaged youth. Using PDSA cycle, the CSA and its partners will test and develop the best ways to partner with each institution to expand access and integrate care. **Project 3, Clinical Pipeline** will support the launch of a robust clinical internship program in partnership with university MSW and other clinical master's degree programs. The Clinical Pipeline Project will provide intensive clinical training and coaching to Masters-level interns, with a focus on strengthening culturally responsive practice in communities of color. The program will support future clinicians to gain comfort in providing home and community-based services in Roxbury, which is currently a barrier to expanding our workforce. The program will also provide a Licensure Testing Support Group to both interns and employees seeking to pass their licensure exam. This project will grow its clinical workforce and clinical supervisory workforce, supporting CSR CSA and IHT to improve timely access to both ICC and IHT services.
D. Plans for improving care coordination, care planning, and care management
Project 1, Quality Monitoring will build the CSA's capacity to support quality monitoring and performance improvement efforts through increased reporting and analysis capability, upgraded mobile technology and strengthened management and staff skills.
Project 2, Pediatric Partnerships will improve care coordination in two ways. First, the CSA will develop strategic partnerships with pediatric providers to foster bidirectional communication.

It will link to the Mass Hi-way, develop Integrated Care Protocols and train CSA staff on these protocols including utilization of the Mass Hi-way for communication with pediatric providers.

E. Plan to improve performance on quality scores and Development Plan goals

Project 1, Quality Monitoring and **Project 2, Pediatric Partners** are focused on improving performance in quality scores and development plan goals.

F. Plans for improving coordination with pediatric primary care

Project 1, Pediatric Partnerships will improve coordination with pediatric primary care through partnerships and CSA protocols.

Section 6.3: Populations Served and Community Engagement *(3 pages)*

A. Member populations and Strategies to initiate and Maintain Engagement

Children's Services of Roxbury is a 50-year old minority-operated nonprofit dedicated to meeting the needs of youth and families of color across Massachusetts through an array of services including foster care and adoption services, affordable childcare, transitional housing for homeless families and children's behavioral health services.

As the Black Specialized CSA, Children's Services of Roxbury specializes in serving youth and families of color without regard to geographic boundary. Geographically, the majority (~ 85%) of Members currently come from Greater Roxbury (Roxbury, Dorchester, Mattapan), with a substantial minority (~14%) from other Boston neighborhoods, and approximately 0.5% from outside Boston, mostly drawing from Quincy, Brockton, Randolph and Dedham. Our Members reflect the diversity of the communities we serve, and include significant populations of African, African American, Latino, Cape Verdean and Haitian. We serve a large immigrant and refugee population as well as families of Islamic faith who are facing increased vulnerability in the current period. Many family members speak a first language other than English, including Spanish, Haitian Creole and Cape Verdean Creole.

Our capacity to initiate and maintain family engagement comes from the decades of trusting relationships built between Children's Services of Roxbury and the community we serve. All our decisions and management practices are informed by our core values: Dignity, Respect, Compassion, Humility, Integrity, Patience, and Excellence. The CSR CSA actively engages in outreach and promotes the value and accessibility of care via involvement in participation in various events and activities, and utilizes several community partnerships as vehicles for ongoing engagement.

Community Relationships to improve ICC services

System of Care: The CSA hosts monthly Systems of Care meetings, open forums for providers, business leaders, policymakers and community members to connect, network, collaborate and review industry news and best practices.

Schools: CSR has formal partnerships with 17 Boston Public Schools, including elementary, middle and high schools through its School-Based Behavioral Health Program.

Boston Public School Behavioral Health Partnerships		
Charles H. Taylor Elementary	*Madison Park Technical High School*	*Holmes Elementary School*
Curley K-8	*Epiphany School*	*Snowden International School*
Match Community Day Charter	*Mattahunt Elementary School*	*City on the Hill (Dudley)*
Dudley Street Neighborhood Charter	*Higginson Lewis K-8*	*Succeed Boston*
Greater Egleston Community High	*Young Achievers Science and Math Pilot*	*Higginson Elementary School*
Haynes Early Education Center	*James W. Hennigan K-8*	

Our School-based Partnership Program was borne out of BPS's struggle to serve thousands of children with significant, untreated behavioral health needs that are often mislabeled as "behavior problems" in the classroom, fueling dropout rates, worsening the achievement gap, and perpetuating the "school-to-prison" pipeline. CSR CSA provides non-billable resources to each partner school in the form of School-based Behavioral Health Coordinators. These School-based Coordinators work with administrative and academic teams to recognize and identify children with behavioral health needs, facilitate referrals to CBHI services and offer teachers coaching and classroom strategies in support of student IEP and 504 Plans. Our School-based Partnership Program also provides on-site Outpatient clinicians who provide individual and group counseling to students, and facilitating access to ICC FT&T or Therapeutic Mentoring services as needed. The CSA also runs a monthly **Parent Café** rotated among our BPS school partners. This community engagement series fosters dialogue and interaction on children's behavioral health and related themes through CSR presentations and guest speakers. It is open to all parents, while the CSA does targeted outreach to parents of children receiving our services. A Family Partner is on-hand to build relationships with parents. Our BPS partnerships expand access to youth in need of ICC services and support more effective advocacy for academic support, special education, after school programs and other needs.

Childcare: CSR operates an early childcare center serving 191 infants and children plus 40 family-based childcare sites with additional services for homeless children and children receiving DCF services. ICC engaged members are referred to these services as appropriate. Additionally, CSR is a member of the Boston Public Health Commission Trauma Informed Collaborative for Families with Young Children (TICFYC), dedicated to upholding trauma-informed childcare service delivery. The collaborative's mission is to cultivate sustainable relationships across agencies, equitable systems and resources to empower and support families and their young children. It includes Martha Eliot Health Center, Greater Boston YMCA, College Bound, Excel Academy Daycare Center, ABCD, and The Home For Little Wanderers.

Child-Serving State Agencies: DMH provides flex funds and camperships to our youth, providing essential resources to ensure progress in treatment. Each month CSR hosts a DMH representative on site to meet individually with our Intensive Care Coordinators and Family Partners regarding new policy in the Department, eligibility for specific services, the application process and services available through and/or outside of DMH. CSR has a strong relationship with **DCF**, and provides an array of foster care, visitation and adoption services. CSR Behavioral Health and Foster Care Programs would like to build a stronger collaboration to serve foster care youth, especially those aging out of care. Increasing CSR Children's Behavioral Health's clinical capacity is key to launching such an initiative**. DYS and Courts:** The CSA maintains a presence in the court system via support and advocacy as needed for families undergoing legal

matters. We also conduct outreach and offer presentations to DYS administrators about CSA services.

Youth Programs: The CSA organizes presentations from organizations providing resources to transition-aged youth, such as **Year Up, More Than Words and Boston Youth Sanctuary**. CSR partners with the **Boston Children's Museum** and their POP (Providing Opportunities to Play) program providing Museum passes at no cost to the families. These passes can be used to encourage parent/child attachment and healthy child development, as incentives or rewards for families meeting care plan goals, or as an activity with a Therapeutic Mentor. POP also affords an opportunity share resources with the other organizations involved including: Brookview House, EMPath (Economic Mobility Pathways), Family Nurturing Center, Father's Uplift, LUK, Inc., Ronald MacDonald House, Shriners Hospital for Children, St. Mary's Center for Women and Children and Thom Child and Family Services. **KROC Center** hosts CSA-sponsored holiday events for families in need annually.

Homeless and Transitional Housing: CSR provides homeless and transitional housing services for families, and is active in a network of housing-related providers. The CSA accesses these services for families as needed.

Colleges and Universities: The CSA has been actively working to form partnerships with clinical Masters degree programs to create a robust internship program and clinical pipeline for CSR. These partnerships enable expansion of quality behavioral health service delivery in 3 key domains: in-home, outpatient & school-based. The following programs are current and potential partners:

Clinical Program	Current Partner	Potential Partner
Boston College School of Social Work	x	
Gordon Conwell	x	
Bridgewater State School of Social Work	x	
Salem State School of Social Work	x	
Simmons School of Social Work	x	
Cambridge College	x	
Springfield (Chelsea)School of Social Work	x	
Eastern Nazerene	x	
Boston University School of Social Work	x	
Rutgers (online)		x
Wheelock School of Social Work	x	
Lesley	x	
Northeastern University	x	
Suffolk University	x	
William James College		X
Smith School of Social Work		X

How partnerships in Section 6.3.B align with the Bidder's proposed project(s) in Section 6.4.A.
The CSA will develop an entirely new set of formal relationships for the **Pediatric Partnerships** project, leveraging the many informal connections between CSR staff and community health centers, MCOs and ACO leaders. The lessons of our **BPS School-based Partnerships** will inform our approach to Pediatric Partnerships, focusing on building one-on-one relationships and emphasizing the value and potential benefit to the institution of accessing the CSA's resources.

Our existing College/University relationships that have been actively cultivated over the past year will serve as the the foundation of the **Clinical Workforce Pipeline project.**

Section 6.4. Proposed Projects and Investment plan

A. Project Description

CSR CSA is proposing 3 projects, described below.

- Project 1: Quality Monitoring
- Project 2: Pediatric Partnerships
- Project 3: Clinical Pipeline

1. Project 1 Name: Quality Monitoring

2. Project 1 Goal and Plan

Specific goal that will be advanced by the project:

- Strengthen fidelity to Wraparound processes, including the care planning, care management and care coordination processes for ICC-Engaged Members and their families

Project Plan: Build the CSA's capacity to support quality monitoring and performance improvement efforts through increased reporting and analysis capability, upgraded mobile technology and strengthened management and staff skills.

3. Project 1 Scope, Duration, Planned Methods & Activities

Project Scope:

CSR will significantly strengthen its capacity to generate standardized quality-focused reports with the installation of EHR Reporting Software. This will allow the CSA leadership and the entire Children's Behavioral Health Senior Team to strengthen its capacity to monitor quality and support performance improvement. Children's Behavioral Health Senior Team will work to define a shared set of standard reports needed to strengthen performance monitoring, focused both on those measures identified by MassHealth and the MCEs, and additional internally generated quality metrics. Some standard reports will be created specifically for the CSA and others will be used across the Children's Behavioral Health department. Managers will receive training on using the Reporting Software to generate their own tailored reports as needed. CSA staff will receive advanced EHR training as well as a Windows-based software suite for use on the new tablets to address gaps in technology skills.

Project Duration:

The duration of the project extends from the Preparation Budget Period through Budget Period 5, with several phases of work described below. The project will take place over all Budget Periods, with the most intensive work in the first three periods.

Project Methods and Activities:

- **Reporting Software Acquisition & Installation:** Project Manager attends intensive two-day training on Reporting Software module in Baltimore MD. CSR purchases and installs Reporting Software module, with coaching support from Credible.
- **Quality Measures, Reports & Dashboard Development:** The Children's Behavioral Health Senior Team and the CSA defines priority Quality Measures that will be tracked and monitored, including MassHealth quality measures, MCE Development Plan goals and internally generated quality metrics. Project Manager convenes & leads Children's Behavioral Health EHR Team to define Report specifications and review/revise drafted Standard Report Templates. EHR data elements are modified if needed to capture additional data. A Quality Dashboard is developed to summarize and monitor key Quality Indicators. Management Team uses reports and makes modifications or requests additional revisions to improve usability.
- **Technology Training:**
  - **Advanced Credible EHR Intensive:** In Budget Period 1, the CSA will develop and deliver a 2-part advanced EHR intensive, designed to strengthen the quality of data entry, increase understanding of why certain data is important, and teach staff how data is used at CSR to monitor quality and support performance improvement. Trainings will be delivered in small groups to support employee learning and content uptake. This training will take place during Budget Period 1 for all CSA staff, and then again in Budget Period 3 for new staff or any staff who needs additional training to strengthen their data collection accuracy or efficiency. To the extent that resources are available, other Children's Behavioral Health staff will also participate in this training.
  - **Windows-based Software**: In Budget Period 2, CSA staff will participate in training on Tablets and Windows-based Software. This training will be delivered in small groups at different levels (i.e. Refresher and Advanced) to support employee learning and content uptake.

4. Proposed Deliverables

- EHR is modified so staff are required to input key data for quality metrics.
- CSA Managers & Supervisors receive regular Reports & Dashboards that allow them to monitor key quality metrics.
- Staff skills are strengthened in use of EHR and Window's suite on tablets.
- CSA staff have upgraded tablets.

5. Specific use of DSRIP funding & how investment will support execution of project goals

Technology Funds (Reporting Software)

- Purchase and install Credible EHR Reporting Software module.

Operational Infrastructure Funds (IT project management, systems performance management capabilities)

- The IT Coordinator will oversee all aspects of this project. He will installation the Reporting module, convene and lead planning meetings the EHR Work Group to define standard

report specifications, produce standard report templates, train CBH supervisors to generate their own additional reports, develop advanced EHR training for staff.

Workforce Development Funds (Training & coaching)

- All CSA staff will receive Advanced EHR Intensive training on Credible and Windows-based Software training.

6. Existing internal resources (e.g. funding, staff, business site, IT systems, hardware)

- Children's Behavioral Health Senior Team, led by the Vice President of Behavioral Health and the CSA Director, will develop the specifications for quality metrics.
- CSR has already made a major investment in Credible Electronic Health Records with mobile capability which will serve as the backbone of this project.
- Electronic Health Records Work Group will invest extensive time developing a system for defining, tracking and monitoring quality metrics.
- Behavioral Health Training Department will provide logistical support for the trainings.
- Basic EHR training & coaching for all staff are already provided by the CSA. The trainings described here are in addition to basic EHR training and coaching.

7. How funds will be allocated across the Bidder's organization and CSA site(s):

CSR CSA only has one site, located in Roxbury. CSR's other Children's Behavioral Health services will indirectly benefit from this investment as well.

8. Internal evaluation, measurement or performance management strategies to demonstrate effectiveness

Quantitative and/or Qualitative Data on Program Activities.

- CSR CSA will track project implementation against its timeline.
- Quality Dashboard will be shared with CSR's CEO, CFO and Board leadership. Feedback on value of Quality Dashboard and Standard Reports in supporting performance monitoring and improvement will be gathered from CBH Senior Team, CEO, CFO and Board leadership. This feedback will be documented in an internal report and used to refine the performance management tools.

Outcome measurements:

- **Specific Measure:** To measure impact CSA will develop/utilize a Quality Dashboard & Quality Reports from Credible Business Intelligence software
- **Goal/Time Point:** By end of BP2, CSA has a quarterly Quality Dashboard summarizing Quality Reports on 7 CSA Quality Measures.
- **Plan:** Internal data collection method.
- **Responsible Staff:** Amos Andrews, Director of Data Analytics and Jessica Bedney, CSA Director

1. Project 2 Name: Pediatric Partnerships

2. Project 2 Goal and Plan

Specific goals will be advanced by the project:

- Foster strong integration with ACOs and primary care providers for ICC-Engaged Members;
- Improving timely access to ICC services for children eligible to receive ICC and their families.

Project Plan: The CSA will strengthen its focus on pediatric/behavioral health integration, develop strong partnerships with interested pediatric providers and expand access to ICC referrals from pediatric practices and hospitals. It will initiate and foster ongoing communication with at least five of the pediatric providers most frequently utilized by our ICC-engaged members and their ACO parent organizations, and develop active partnerships with at least two pediatric providers. Based on lessons learned, assess and implement opportunities for replication and expansion. The CSA will strengthen its own capacity to collaborate with pediatric providers. It will develop protocols and supervisor capacity to support health/behavioral health integration around prevention and wellness, avoidable utilization, follow-up after mental illness hospitalization, and strengthened care coordination. The CSA will develop protocols for communicating with pediatricians, including using the Mass Hi-way to support written information-sharing. The CSA will identify new EHR data elements that allow management to monitor practice change. The CSA will train and coach CSA staff on the new expectations for delivering integrated care, the reasons behind it including the ways in which chronic conditions such as asthma, diabetes and obesity which are known to exacerbate mental health conditions, and best practices for communicating with pediatricians.

3. Project 2 Scope, Duration, Planned Methods & Activities

Project Scope:

Over 87.5% of pediatricians seen by ICC-engaged members are concentrated in 12 provider organizations, all within 5 miles of the CSA's office. will take place in phases.

Pediatric Provider	Approximate % of ICC-Enrolled Youth Served
Children's Hospital	20%
Boston Medical Center	10%
Codman Square Health Center	10%
Harvard Vanguard	7.5%
Dimock Community Health Center	5%
Uphams Community Health Center	5%
Whittier Street Health Center	5%
Harvard Street Health Center	5%
Dorchester House	5%
Martha Elliot Health Center	5%
Mattapan Community Health Center	5%
South End Community Health Center	5%
Other	12.5%

The project will begin with Engagement and Assessment period, and then follow with two Plan, Do, Study, Act (PDSA) cycles. Our PDSA timeline is informed by experience of our colleague CSAs who shared their experiences forging partnerships with health providers. The final phase includes an assessment of potential for replication, based on resource availability.

Simultaneous with pediatric outreach and engagement efforts, CSR CSA will begin to build its internal capacity to collaborate with pediatric providers. This work will take place through a series of steps, including joining the Mass Hi-way, developing CSA basic protocols and expectations for ICC pediatric communication, building new data elements into the EHR, developing reports for monitoring, training CSA staff on the relationship between common childhood chronic conditions and behavioral health, and coaching staff toward practice improvement on pediatric communication.

Project Duration:
The duration of the project extends from the Preparation Budget Period through Budget Period 5, with several phases of work described below.

Methods and Activities:

- **Engagement:** During the Engagement phase, the CSA will reach out to five providers from this list, based on a combination of factors including % of ICC-enrolled youth served, proximity, ease of access and known partnerships with other CSAs. Engagement will involve reaching out to multiple individuals at different levels of the organization, such as the CEO, Pediatrics and Outpatient Behavioral Health services. The CSA will also reach out to the ACO leadership of these same providers, particularly Children's Hospital ACO, BMC ACO and Community Care Cooperative ACO.
- **Assessment:** The CSA will assess the interest of each provider, and identify two Pediatric Providers who are most responsive to the CSA's outreach efforts. The Assessment will include documentation of ideas generated with the provider for increased collaboration, including potential strategies to strengthen cross-training, bi-directional communication, referrals and care coordination. The CSA will identify the leaders at each organization who will serve as the Point of Contact in collaborative planning with the CSA.
- **Partnership Plan, Do, Study, Act Cycles:**
  Plan: The Partners will involve identifying a shared goal, formulating a theory of change, defining success metrics and putting a plan into action. The CSA and the providers will develop a pilot Plan for increased collaboration, with agreed-upon modest, measurable benchmarks to assess progress in at least two of following areas: cross-training, bi-directional communication, referrals and care coordination. The CSA will draw on its successful experiences building collaborations with Boston Public Schools which as highlighted the importance of relationship building through a single point of contact and a regular onsite presence. Although the specific plan will be developed with each provider, the CSA anticipates that relationship-building will be central to the success of this project. A CSA Clinic Coordinator will serve as a single point of contact, and specific Intensive Care Coordinators and Family Partners may develop a regular presence at the provider site, to the extent possible. The CSA with each partner will implement a Pilot to test the plan and

track success against benchmarks. The CSA and each partner will identify and document both successes and barriers to increased collaboration. The CSA and its partners will make mid-course adjustments, and then repeat the PDSA cycle with the same Pediatric Partners, moving forward to deepening the collaboration.

- **Assess Replication Opportunities:** Based on lessons learned, the CSR CSA will assess it capacity to take on additional partners and opportunities to replicate the process, as resources allow.
- **Join Mass Hi-way:** CSR CSA will join Mass Hi-way's email system to strengthen its capacity for secure communication with pediatricians. Initially supervisors will initially be trained to use the Mass Hi-way email system. As part of its integrated care training, CSA staff will learn to use the Mass Hi-way for pediatric communication.
- **CSA Integrated Care Protocols:** Develop, test, revise & implement CSA Integrated Care Protocols, informed by its engagement and assessment activities with pediatric providers (see above) and analysis of new CSA Quality Measures.
- **New Data Elements & Reports:** Build relevant new data elements into EHR & monitoring implementation.
- **Train Staff:** Introductory Integrated Care training for CSA supervisors, then for CSA staff, as well as Advanced CSA integrated care cross-training with Provider Partners. Training content includes: a) The link between chronic childhood conditions and behavioral health b) Realistic strategies for coordinating with pediatric practices c) CSA Protocols and Expectations, including new EHR elements and use of Mass Hi-way.
- **Identify any additional capacity-building needs**, based on lessons learned.

4. Proposed Deliverables

- CSR CSA has active strategic partnerships with at least 2 key providers of pediatric primary care to our ICC-engaged members.
- CSR CSA has standard baseline protocols for ensuring well visits, monitoring hospital & pediatric communication.
- CSR CSA meets health metrics.
- CSR CSA is on the Mass Hi-Way.

5. Specific use of DSRIP funding & how investment will support execution of project goals.

Operational Infrastructure Funds (Systems change resources, operational support)

- **Pediatric Partners Project Manager**, reporting to the CSA Director, will oversee all aspects of this project, including Pediatric provider engagement, assessment, partnership development, protocol development and staff training. **An adjustment to the budget has been proposed ($25,848 to $25,000).*

Technology Funds (Mass Hi-way)

- Connect to **Mass Hi-Way.**

Workforce Development (Training & coaching)

- **Introductory and Advanced Training on Integrated Care** will be provided to CSA supervisors and staff.

6. Existing internal resources (e.g., funding, staff, business site, IT systems, hardware)
Internal resources include Behavioral Health Senior Team leadership, Credible Electronic Health Records, Behavioral Health Electronic Health Records Work Group, informal relationships with several Greater Roxbury community health centers, relevant lessons from BPS partnership, BH Training Department.

7. How funds will be allocated across the Bidder's organization, and CSA site(s):
CSR CSA only has one site, located in Roxbury.

8. Internal evaluation, measurement or performance management strategies to demonstrate effectiveness

- **Quantitative and/or Qualitative Data on Program Activities.**
  - Qualitative data will be kept on provider engagement and on PDSA lessons learned with Pediatric Partners.
  - Benchmark metrics for tracking and measuring success will be developed with Pediatric Partners.
- **Outcome measurements:**
  - **Specific Measure:** To measure impact CSA utilize referral report generated by Credible EHR.
  - **Goal/Time Point:** By end of BP 5, CSA receives at least 24 referrals from Pediatric Partners (average 1/month/partner).
  - **Plan:** Internal data collection method.
  - **Responsible Staff:** Harry Harding, Vice President, Innovation & Strategic Partnerships and Jessica Bedney, CSA Director

1. Project 3 Name: Clinical Workforce Pipeline

2. Project 3 Goal & Plan

Specific goal that will be advanced by the project:

- Strengthening fidelity to wraparound processes including care planning, care management and care coordination.

Project Plan: This project seeks to increase the pipeline of Masters level clinicians who provide home and community-based ICC services in Greater Roxbury. Clinical Workforce Pipeline Project will support the launch and development of a robust internship program in partnership with university MSW and other clinical master's degree programs, and the transition from internship to CBHI employment at CSR.

3. Project 3 Scope, Duration, Planned Methods & Activities

Scope:

The Clinical Pipeline Project starts with intensive relationship-building with clinical programs in Greater Boston. The foundation for these relationships has been laid, but much work remains in developing detailed plans to partner with each university or college. The project includes individualized outreach strategies for each university. It involves curriculum development to provide intensive clinical training for our interns, with a focus on strengthening culturally responsive practice in communities of color. The project will actively assist interns to gain comfort in providing home and community-based services in Roxbury, currently a barrier to expanding our workforce. Through individualized transition planning, the project will also actively support the transition from internship to employment in CSR CSA and IHT. The program will also provide a Licensure Testing Support Group to both interns and employees seeking to pass their licensure exam.

Duration:

The duration of the project is Preparation Budget Period through Budget Period 3, with the potential to extend the project if additional resources become available through ICC service expansion.

Methods and Activities:

The following steps will be taken to establish a Clinical Workforce Pipeline:

- **Strengthen, Expand and Formalize Each College Partnership:** The Project Manager will cultivate and develop relationships with each Department chair, field placement administrator and Field Instructor. He will gather specific department requirements and expectations, attend Intern Supervisor trainings and maintain quarterly contact with Field Instructor, including review of requirement, progress and evaluation.
- **Develop, test and revise weekly Intern Study Group curriculum:** CSR CSA seeks to be known as an organization who invests in and supports its interns in their growth and

development as clinicians. Interns will attend a weekly Intern Study Group facilitated by the Project Manager that includes a mix of case reflection, clinical skill development and information on community resources presented by internal and outside speakers.

- **Develop and Implement Recruitment Plan:** The Project Manager will develop and implement an individualized plan with each college or university, attending Open Houses, job fairs, speaking in classes and other recruitment activities. He will cultivate, interview & select MSW, LMHC and LMFT interns. As the program grows, he will engage current interns to share information with their peers about CSR CSA's internship program.
- **Individualized Support and Transition Planning:** Beyond the standard clinical coaching provided to all ICCs and IHTs, the Project Manager will provide individualized support to interns, helping interns navigate their new environment, facilitating emergency School and agency meetings for students in crisis, and writing Intern semester evaluations.
- **Transitioning to Employment:** For interns who are graduating from their clinical programs, the Project Manager will provide individualized information and support on transitioning to employment at the CSR CSA.
- **Licensure Exam Study & Support Group:** In 2016-2017, CSR CSA received funding from Commonwealth Corporation to pilot a Licensure Testing Support Group. CSR CSA had noticed that many experienced and knowledgeable clinicians of color avoided taking their licensure exams or froze during the exam and didn't pass. The shortage of licensed clinicians seriously hampers the potential for expanding access to CBHI services. The pilot successfully supported several CSR clinicians to pass their licensure exams. The Licensure Exam Study & Support Group will be re-instated as part of this project, providing access to test-taking practice resources, technical coaching on exam questions from licensed clinicians, skill-building around testing anxiety and peer support.

4. Proposed Deliverables

- At least 8 sustained university partnerships.
- Intensive outreach to universities, resulting in 24 clinical interns/year by Year 3.
- Internship Training and Support Program enhancing standard clinical supervision and training with weekly Intern Study Group, intensive individualized coaching and supports, and transition to CSR CSA or CBHI employment.
- Licensure Exam Study & Support Group

5. Specific use of DSRIP funding & how investment will support execution of project goals.

1. Workforce Development (recruitment supports, training, coaching programs, and certifications)

- Project Manager for recruitment, training, coaching and licensure
- Intern training & development resources

6. Existing internal resources (e.g., funding, staff, business site, IT systems, hardware)

- To support a strong program launch, CSR will provide initial funding for the Project Manager in Summer/Fall 2017 until the grant begins.
- Clinical onboarding, supervision will be adapted to support interns.

- EHR training and coaching will be provided to interns.
- CSR CSA training will be provided to all interns.

7. How funds will be allocated across the Bidder's organization, and CSA site(s):

CSR CSA only has one site, located in Roxbury. CSR's other Children's Behavioral Health services will indirectly benefit from this investment as well.

8. Internal evaluation, measurement or performance management strategies to demonstrate effectiveness

Quantitative and/or Qualitative Data On Program Activities.

- The project will collect and monitor the following data:
  - # of universities participating in the project.
  - # of participating interns from each university/college
  - # of interns who become CSR clinicians, including the # of LICSWs
  - # of interns who become CSR supervisors over the project's duration
  - # of CSR clinicians who pass their licensure exam after participating in CSR Licensure Coaching and Support Group.
- The project will use a survey monkey to gather feedback from:
  - Field instructors
  - Interns
  - Other university contacts as appropriate.

Outcome measurements:

- **Specific Measure:** To measure impact CSA will develop Clinician Pipeline Recruitment/Retention Report generated by Credible EHR.
- **Goal/Time Point:** 25% of second year clinical interns become employed as CSR clinicians who serve CSA-engaged members.
- **Plan:** Internal data collection method.
- **Responsible Staff:** Darryl Huggins, Outpatient Program Manager and Jessica Bedney, CSA Director

B. Project Team description

CSR CSA is poised and eager to begin this project. Organization's level of readiness and proposed Project Team for implementing the proposed project(s), including:

B. An BH Dept. organizational chart is attached.

1. 2. The Project Team consists of:

- Salesia Hughes, Vice President of Behavioral Health
- Jessica Bedney, CSA Director
- Harry Harding, Vice President, Innovation & Strategic Partnerships
- Amos Andrews, Director of Data Analytics
- Darryl Huggins, Outpatient Program Manager

Roles, Job Descriptions and Qualifications

Team Leadership: Vice President of Behavioral Health, Salesia Hughes and CSA Director, Jessica Bedney will provide leadership, oversight and evaluation of all projects. Their time is funded as an in-kind resource from CSR. Salesia Hughes has been the Vice President of Behavioral Health at CSR for 3 years after serving as CSR CSA Director since its founding in 2008. Jessica Bedney has served as CSA Director for 4 years, after having started the Behavioral Health Training Department and previously serving as a Senior ICC. She also served as a statewide CSA Coach for 5 years.

Project Management: Overall contract and project management will be provided by **Harry Harding, Vice President, Innovation & Strategic Partnerships**. Contract management time is funded as an in-kind resource from CSR. Harry Harding served on the Behavioral Health Senior Team and led training and quality improvement initiatives for the CSR CSA. Harry leads various outreach efforts, consults on multiple internal projects and has previously managed a large training and quality improvement grant for CSR CSA. With a graduate degree in organizational development, Harry brings extensive experience in large project management.

2. Quality Monitoring Project Manager: Amos Andrews, Director of Data Analytics will manage all aspects of the Quality Monitoring project. Amos managed all aspects of CSR Behavioral Health's conversion to Credible Electronic Health Records, including project planning, management and implementation. He will also convene and lead the CSR EHR team to define new EHR data elements the development Quality Report templates.

Pediatric Partnerships Project Manager: Harry Harding will manage all aspects of the Pediatric Partnership Project, in addition to his in-kind overall grant management role. Harry's relationship-building expertise will guide this strategic partnership endeavor. His role as Vice President of Innovation & Strategic Partnerships will enable him to spearhead the change process at CSR CSA toward improved practice in integrated care coordination and care management, and to support the development of CBHI training for pediatric providers, ACOs and MCOs.

Clinical Workforce Pipeline Project Manager: Darryl Huggins, Outpatient Program Manager, will manage all aspects of the Clinical Workforce Pipeline project. Darryl Huggins leads the programmatic development of the Outpatient program including managing partnerships with Boston Public Schools and college/universities. Darryl has significant experience working in behavioral health including several years working as an ICC for the CSR CSA.

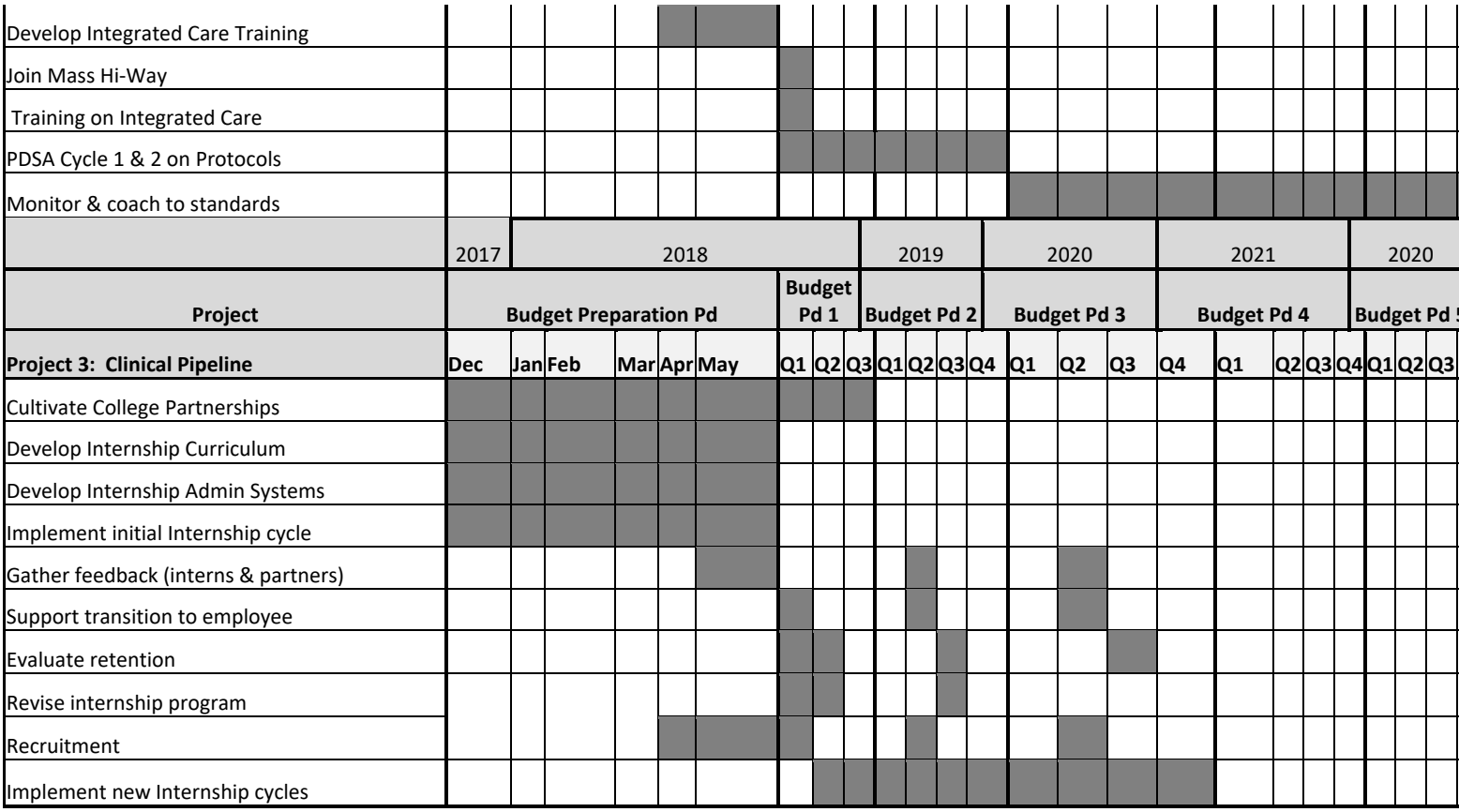
Project Management and Coordination Among Staff:

Harry Harding will oversee all aspects of Project Management, serving as the single point of contact, convene the Project Team, oversee the implementation plan, ensure deliverables, coordinate among the various projects and support effective evaluation.

C. Implementation Plan and Timeline

	2017	2018								2019				2020				2021				2022			
	Budget Preparation Pd						Budget Pd 1			Budget Pd 2				Budget Pd 3				Budget Pd 4				Budget Pd			
Project	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	
Project 1: Quality Monitoring																									
Evaluate Reporting Software options																									
Purchase Reporting Software																									
Training for Project Manager																									
Install and test Reporting Software																									
Train managers on quality measures																									
Develop quality monitoring domains																									
Identify new data elements for EHR																									
Add new data collection elements																									
Develop & revise Report templates																									
Develop & revise Quality Dashboard																									
Training Managers to create reports																									
Coach Managers to create reports																									
Advanced EHR Training																									
Train CSA staff: Software																									

Project 2: Pediatric Partnerships	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
Engage 5 Pediatric Providers																								
Assess and select Partners																								
Identify Planning Teams																								
With each Partner, PDSA Cycle 1																								
With each Partner, PDSA Cycle 2																								
Develop sustainability plan																								
Assess replication opportunities																								
Engage new Pediatric Providers																								
Replicate as resources allow																								
Develop Integrated Care Protocols																								
Train Supervisors on Protocols																								



D. Budget Report and Budget Narrative

See Attachments B and C.

E. Sustainability

The Quality Monitoring project is building permanent management capacity and practice in monitor program quality. It will foster sustainable practices in using data to manage performance improvement efforts, creating standard templates and increasing manager skill and creating their own reports. CSR management is highly invested in sustaining the work after the project ends. Financially, it plans to continue the relatively small annual fee for the EHR Reporting software use after the project is completed.

The Pediatric Partnership project will be designed with sustainability in mind. While the initial partnership-building and coordination efforts will be infused with staff-intensive resources, the goal of the project is to institutionalize coordination, communication and referral processes that do not require sustained investment. As CSR CSA builds its own capacity to engage pediatric providers, it will continue to build relationships that expand beyond the original partners in the grant.

The Clinical Workforce Pipeline project is intended to generate lasting partnerships with universities and colleges. The project will establish foundational systems and relationships,

with the goal of establishing a reputation for CSR CSA as a valuable and desirable place for internships and employment. The project's success will pave the way for its sustainability. If the project is successful in cultivating future clinical employees, CSR CSA will continue to invest in the staffing required to sustain the Clinical Workforce Pipeline.

Section 6.5 Coordination with ACOs, MCOs, and Primary Care Providers (3 pages)

Bidirectional communication between the Bidder and pediatric practices

1. As part of its Pediatric Partnership project, the CSA will work to develop bidirectional communication with pediatric practices. The CSA will work at multiple levels to achieve bidirectional communication.
2.
3. **At the Care Team level,** the CSA will establish Integrated Care Protocols and train ICCs to use the Mass Hi-way to share Care Plans with the child's pediatrician for all ICC-engaged members. ICCs will reach out to the pediatrician through the Mass Hi-way system, inviting communication and engagement around the youth's Care Plan.
4.
5. **At the institutional level,** the CSA will seek to engage leaders of priority ACOs, community health centers and other pediatric providers to support more intentional and consistent communication. The CSA will offer to assign a Clinic Coordinator as a point of contact for the provider, coming onsite on a regular schedule for the duration of the project to facilitate referrals, coordinate medical team trainings on CBHI services, or otherwise facilitate bidirectional communication as required.

Referral management protocols for follow-up and informational sharing

As part of the Pediatric Partnership project, the CSA and its partners will develop referral management protocols including expectations for consistent follow-up and information-sharing for pediatric referrals. As described earlier, the PDSA cycle will be used to test and adjust to ensure ease of use.

Team-based treatment planning in collaboration with pediatric practices

6. The CSA and its partners will experiment with various options for Team-based treatment planning in collaboration with pediatric practices. Recognizing the context of time pressures on pediatric providers, options for skype participation, phone communication and written input via email into the team planning will be considered. The CSA will also explore the option, at the parent's request of a Family Partner joining the parent at pediatric well visit to bridge communication with the pediatrician.

Timely access to ICC services; and

A key goal of the Pediatric Partnership project is to increase timely access to ICC services. The ICC service needs to be top of mind for pediatricians, which is supported by a regular point of contact, increased information about ICC and other CBHI services, an easy-to-find referral process and regular pediatric updates about families receiving the ICC service.

Connections to social services.

The Pediatric Partnership project will open the doors to providing pediatricians with additional social service resources for youth in need of Intensive Care Coordination. Through ICC, pediatricians support families with complex needs to access expanded social service supports to address food instability, housing instability, school services or other social service needs.

CSA Budget Report

Children's Services of Roxbury

Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites	1	1	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate	NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)	194	194	194	194	194	194	
Estimated Funds	$ 122,856.00	$ 135,800	$ 81,480	$ 58,200	$ 51,216	$ 23,280	**$ 472,832**
At- Risk Withhold Rate			5%	10%	15%	20%	
Withhold			$ 4,074	$ 5,820	$ 7,682	$ 4,656	**$ 22,232**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 122,856.00	$ 135,800	$ 77,406	$ 52,380	$ 43,534	$ 18,624	**$ 450,599.60**

Investment Projects	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Project 1 Name: Quality Monitoring							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ 20,000	$ 20,000	$ 12,000	$ 2,000	$ 2,000	$ -	**$ 56,000**
Reporting Software	$ 57,856	$ 6,435	$ 8,580	$ 8,580	$ 8,580	$ 8,580	**$ 98,611**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ 4,000	$ 4,000	$ 4,000	$ -	$ -	**$ 12,000**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 1 Total	$ 77,856	$ 30,435	$ 24,580	$ 14,580	$ 10,580	$ 8,580	**$ 166,611**
Project 2 Name: Pediatric Partnerships							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure							
Operation Staffing including Fringe	$ 25,000	$ 24,000	$ 23,220	$ 21,130	$ 13,660	$ 1,140	**$ 108,150**
Other Operational Expenses	$ -	$ 2,300	$ 1,800	$ 1,800	$ 1,800	$ 1,800	**$ 9,500**
Project 2 Total	$ 25,000	$ 26,300	$ 25,020	$ 22,930	$ 15,460	$ 2,940	**$ 117,650**
Project 3 Name: *Clinical Workforce Pipeline*							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ 19,500	$ 19,495	$ 20,000	$ 6,050	$ -	$ -	**$ 65,045**
Recruitment Expenses	$ 500	$ 170	$ -	$ -	$ -	$ -	**$ 670**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**

Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 3 Total		$ 20,000	$ 19,665	$ 20,000	$ 6,050	$ -	$ -	**$ 65,715**
Total Project Costs		$ 122,856	$ 76,400	$ 69,600	$ 43,560	$ 26,040	$ 11,520	**$ 349,976**
Indirect Costs/ Administrative Overhead Rate		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Investment Projects Total		$ 122,856	$ 76,400	$ 69,600	$ 43,560	$ 26,040	$ 11,520	**$ 349,976**

CSA Budget Report - Budget Narrative Prep Budget Period

CSA Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name: Quality Monitoring

DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care planning,*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Project Manager	$ 75,000.00	0.55	5	$ 17,188
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0.55		$ 17,188
	Fringe rate	17.0%	Total Fringe	$ 2,812
Total IT Staffing including Fringe				$ 20,000

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project. Quality Monitoring Project Manager: Amos Andrews, Internal Projects Manager/EHR Administrator, will manage all aspects of the Quality Monitoring project. Amos managed all aspects of CSR Behavioral Health's conversion to Credible Electronic Health Records, including project planning, management and implementation. He will also convene and lead the CSR EHR team to define new EHR data elements the development Quality Report templates. He will install the reporting module, convene and lead planning meetings with the EHR work group to define standard report specifications, produce standard report templates, train CSA supervisors, develop advanced EHR training for staff.

Reporting Software

Description of Expense	
Purchase of Electronic Health Record	$ 57,856.00
reporting software for CSA	
Total Development and Adaptation of EHR and Care Management System	$ 57,856.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined: As a result of the project's prep budget the management team along with the Project Manager will be able to design reports along with dashboards to facilitate in assisting in timely access to ICC services. By tracking encounters, face to face visits, know how much time is being delivered to ICC engaged members each week. CSA managers will have all this information and much more at the push of a button to ensure the quality of care for each member and how each clinician is meeting standards of care. The cost was determined by Electronic Healthcare Record software vendor, CREDIBLE. The Credible Business Intelligence Module is an enhancement to the current EHR system.

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Pediatric Partnerships

DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name: Clinical Workforce Pipeline

DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care planning*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total IT Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Workforce Development - Prep Budget Period

Project 1 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name: Clinical Workforce Pipeline

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Project Manager	$ 62,012.00	0.81	4	$ 16,640
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0.81		$ 16,640
	Fringe rate	17.0%	Total Fringe	$ 2,860
Total Workforce Development Staffing including Fringe				$ 19,500

The Clinical Workforce Pipeline Project Manager's goal is to expand the workforce of Masters level clinicians and licensed Supervisors prepared to work in homes and neighborhoods in Greater Roxbury communities of color. To create this clinical pipeline, the Project Manager will develop a robust internship program in partnership with university Social Work Schools and other clinical masters-level degree programs. The Project Manager will establish, strengthen and formalize at least 8 university partnerships, cultivating relationships with each Department chair, field placement administrator and field instructor. He will gather specific department requirements and expectations, attend Intern Supervisor trainings and maintain quarterly contact with Field Instructor, including review of requirements, progress and evaluation. The Project Manager will develop and implement recruitment, screening and selection of appropriate MSW, LMHC and LMFT interns. The Project Manager will coordinate one or more Intern Study Groups designed to enhance standard clinical supervision and training. For interns who are graduating from their clinical programs, the Project Manager will provide individualized information and support on transitioning to employment at Children's Services of Roxbury CSA.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Expenses

Description of Expense	Cost
Internship speaker series honoraria	$ 500.00
Total Training Expenses	$ 500.00

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined: The Clinical Workforce Pipeline Project Manager will seek specialized training support from an identified resource with clinical expertise to benefit interns participating in the developmental pipeline. The honoraria will be afforded to the identified resource who may provide guidance around best practice for care integration, assessment and as needed offering overview of Clinical & Psychosocial for the CSR CSA service population. The $500 is an estimated cost for the time of the identified resource.

Internships honorarium project will cover 5 speakers 100$ each

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Workforce Development Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 1 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Pediatric Partnerships

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Project Manager	$ 80,000.00	0.8	4	$ 21,333.33
Project Manager In-kind	$ 80,000.00	0.2	0	$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	1		$ 21,333.33
	Fringe rate	17.0%	Total Fringe	$ 3,666.67
Total Program Staffing including Fringe				$ 25,000.00

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project: Pediatric Partnerships Project Manager will manage all aspects of the Pediatric Partnership Project, in addition to his in-kind overall grant management role. The project manager will spearhead the change process at CSR CSA toward improved practice in integrated care coordination and care management, and to provide CBHI training for pediatric providers, ACOs and MCOs.
The in kind .2 FTE will focus on training development

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
Total Program Staffing including Fringe				$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate:

Provide a brief description of how the Indirect Cost/ Please note that during our Prep Budget period only, our admin will be "in-kind". Beyond the prep period, during the project periods , our admin rate will be fifteen percent.
Administrative Overhead rate was determined:

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS March 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
Project 1	Quality Monitoring	Implement care management software	01/01/18	12/31/18	**Technology**	Development Adaptation of EHR and/or Care Management System	Analysis/selection of reporting software	Reporting software purchased						
Project 1	Quality Monitoring	Build the CSA's capacity to support quality monitoring and performance improvement efforts through increased reporting and analysis capability	01/01/18	01/01/20	**Operational Infrastructure**	Operation Staffing including Fringe	Project Manager attends E.H.R. software specialized training in January	Project Manager attends E.H.R. software specialized training						
Project 2	Pediatric Partnerships	CSA will strengthen its focus on pediatric/behavioral health integration, develop strong partnerships with interested pediatric providers and expand access to ICC referrals from pediatric practices and hospitals.	01/01/18	01/01/21	**Workforce Development**	Operation Staffing including Fringe	Project Manager begins engagment phase	Project Manager identifies 5 key contacts for outreach/engagement						
Project 3	Clinical Workforce Pipeline	Establish/cultivate university partnerships to develop Masters-level clinicians and particularly licensed clinicians qualified to serve as ICC Supervisors	01/01/18	01/01/21	**Workforce Development**	Workforce Development staffing including Fringe	Project Manager begins recruitment phase	Project Manager identifies 8 key contacts for university partnerships						
Project 3	Clinical Workforce Pipeline	Implement specialized support to internship development	01/01/18	06/30/18	**Workforce Development**	Other Operational Expenses	Identify resource for honoraria	Speaker identified; scheduled						
					Workforce Development	Training Expenses								
					Workforce Development	Retention Expenses								
					Operational Infrastructure	Operation Staffing including Fringe								
					Operational Infrastructure	Other Operational Expenses								
					Operational Infrastructure									
					Operational Infrastructure									

CSA Budget Report

The Home for Little Wanderers

Investment Funding		Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites		2	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate		NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)		173	173	173	173	173	173	
Estimated Funds		$ 176,052	$ 121,100	$ 72,660	$ 51,900	$ 45,672	$ 20,760	**$ 488,144**
At- Risk Withhold Rate				5%	10%	15%	20%	
Withhold				$ 3,633	$ 5,190	$ 6,851	$ 4,152	**$ 19,826**
TOTAL MAXIMUM FUNDS AVAILABLE		$ 176,052	$ 121,100	$ 69,027	$ 46,710	$ 38,821	$ 16,608	**$ 468,318**
Investment Projects		**Prep Budget Period**	**Budget Year 1**	**Budget Year 2**	**Budget Year 3**	**Budget Year 4**	**Budget Year 5**	**Total Expenses**
Project 1: Client Centered Care (Technology Project)								
DSRIP Goal(s) Addressed:	Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System		$ 11,160	$ -	$ -	$ -	$ -	$ -	**$ 11,160**
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses		$ 62,346	$ -	$ -	$ -	$ -	$ -	**$ 62,346**
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 1 Total		$ 73,506	$ -	$ -	$ -	$ -	$ -	**$ 73,506**
Project 2 Name: *Workroce Development*								
DSRIP Goal(s) Addressed:	Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
	Goal 2:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System			$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development								
Workforce Development staffing including Fringe		$ 68,750	$ 96,250	$ 57,750	$ 41,250	$ 34,050	$ 14,565	**$ 312,615**
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses		$ 12,000	$ 10,000	$ 2,800		$ -	$ -	**$ 24,800**
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 2 Total		$ 80,750	$ 106,250	$ 60,550	$ 41,250	$ 34,050	$ 14,565	**$ 337,415**
Total Project Costs		$ 154,256	$ 106,250	$ 60,550	$ 41,250	$ 34,050	$ 14,565	**$ 410,921**
Indirect Costs/ Administrative Overhead Rate	14%	$ 21,796	$ 14,850	$ 8,477	$ 5,460	$ 4,771	$ 2,043	**$ 57,397**
Investment Projects Total		$ 176,052	$ 121,100	$ 69,027	$ 46,710	$ 38,821	$ 16,608	**$ 468,318**

CSA Budget Report - Budget Narrative Prep Budget Period

CSA Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name: Client Centered Care Coordination Project

DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-Eng*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Electronic Health Record Enhancements	$ 11,160.00
Total Development and Adaptation of EHR and Care Management System	$ 11,160.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

These funds will be utilized to contract with NetSmart to work on the PCP information fields and imbedding ICC care plans in Evolv as well as creating custom fields for ICC staff to enter information into the electronic health record so that they have seamless access to cleint information on Evolv coupled with tablet technology.
Rate is based on previous similar contracting rates with the same vendor. Anticipated rate of contracting with NetSmart is $120/ hour ; we anticipate 93 contracting hours to do form script updates, custom form development, form updates and testing in Evolv.

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Microsoft Surface Book (256 GB, 8 GB RAM, Intel Core i5)	$ 39,200.00
Case Logic 15-Inch Laptop and Tablet Briefcase, Black (dlc-115)	$ 946.00
Sophos Hard Drive Encryption Software	$ 4,800.00
Imaging & Deployment by Winxnet	$ 14,400.00
Project Management by Winxnet	$ 3,000.00
Total Other Technology Expenses	$ 62,346.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:
40 Microsoft Surface Book (256 GB, 8 GB Ram, Intel Core i5) at $980 per tablet.
40 Case Logic 15-Inch Laptop and Tablet Briefcase, Black (DLC-115) at $23.68 per case.
40 Sophos Hard Drive Encryption Software at $120 per tablet
Imaging & Deployment by Winxnet at $360 per tabletfor 40 tablets: Loading the tablets with the encryption software, MS Office Software and delivery & installment of the tablets to the end use.
Project Management by Winxnet at $75 per tablet for 40 tablets: Vendor manages the resources needed to accomplish tablet set up and roll out.
The projected break down of distribution of Microsoft Tablets and Tablet Briefcases is as follows:
Hyde Park : Program Director: 1,
Senior ICC current:0, Senior ICC open position: 1,
ICC current: 7, ICC open position: 2,
Interns current :3, Interns open position 1.

Park Street: Program Director: 1,
Supervising Program Director:1,
Senior ICC current:2, Senior ICC open position: 1,
ICC current: 9, ICC open position: 3,
Interns current 1, Interns open position 3.
Project Team members : Trainer :1, Recruiter: 1, Sen.Dir. or Behv Health:1,
Dir of Electronic Health Systems:1

Project 2 Name: Workforce Development

DSRIP Project Goal(s):
1 *(2) Strengthening fidelity to Wraparound processes, including the care planning*
2 *(3) Improving timely access to ICC services for children eligible to receive ICC on*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Workforce Development - Prep Budget Period

Project 1 Name: Workforce Development

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Wraparound Trainer	$ 72,000.00	1	5	$ 30,000
Recruiter	$ 60,000.00	1	5	$ 25,000
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	2		$ 55,000
	Fringe rate	25.0%	Total Fringe	$ 13,750
			Total Workforce Development Staffing including Fringe	$ 68,750

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.
The salaries are based on mid-points in HFLW existing pay scale for comparable positions
The Trainer will be primarily responsible for the internal training, tracking, and scheduling of Wraparound for our CSAs. Esssential Functions include, but not limited to
--Deliver Wraparound Tier 1 and 2 trainings for Intensive Care coordinators and Family Partners at our CSA programs upon hire and annually to ensure and maintain our high fidelity wraparound practice
--Provide IHT and OP staff basic wraparound training to enhance skills for when they are the clinical hub to CBHI services
--Conduct training in both large group and individual forums
The Recruiter will be responsible for achieving the agency's staffing objectives by recruiting and evaluating job candidates and partnering with CBHI hiring managers to complete the vacancy fulfillment process.This individual will Source, screen and/or interview candidates for a variety of positions and building a proactive pipeline of qualified candidates for CSA and other CBHI programs priority roles.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Performance and Retention Bonus	$ 12,000.00
Total Retention Expenses	$ 12,000.00

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Sign on bonuses are distributed on a case by case basis. Typically HFLW offers up to $2000 sign on bonus for highly qualified candidates for positions that are challenging to fill.
We plan on hiring 2 Senior ICC, 2 MA level ICC, 2 BA level ICCs with language capacity (i.e.:Spanish, Haitian-Creloe) at $2000 per hire.

Project 3 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 1 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate: 14%

Provide a brief description of how the Indirect Cost/Administrative Overhead rate was determined:
Historically HFLW has found the overhead expenses to be at 14%.

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS March 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
Projec 1	Client Centered Care (Technology Project)	Tablet roll out and utilization in the field	01/15/18	05/31/18	**Technology**	Other Technology Expenses	Tablet roll out and utilization in the field	staff using the tablets in the field						
Project 1	Client Centered Care (Technology Project)	ICC care plans imbedded in Evolv	02/15/18	07/30/18	**Technology**	Development Adaptation of EHR and/or Care Management System	ICC care plans imbedded in Evolv	staff utilizing the form in Evolv						
Project 2	Workforce Development	Trainer hired	01/15/18	03/31/18	**Workforce Development**	Workforce Development staffing including Fringe	Trainer hired	position filled						
Project 2	Workforce Development	Recruiter hired	01/15/18	03/31/18	**Workforce Development**	Workforce Development staffing including Fringe	Recruiter hired	position filled						
Project 2	Workforce Development	Training plan created	01/04/18	07/31/18	**Workforce Development**	Workforce Development staffing including Fringe	Training plan draft in progress	Evidence of trainer conducting meetings with key staff and a draft of recommendations						
Project 2	Workforce Development	Recruitment strategic plan created	01/04/18	07/31/18	**Workforce Development**	Workforce Development staffing including Fringe	Recruitment strategic plan draft in progress	Evidence of recruiter conducting meetings and focus groups with key staff and a draft of recommendations						
					Workforce Development	Retention Expenses								
					Operational Infrastructure	Operation Staffing including Fringe								
					Operational Infrastructure	Other Operational Expenses								
					Operational Infrastructure									
					Operational Infrastructure									

The Home For Little Wanderers

Section 6.2 Executive Summary

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A. HFLW's current performance on its Development Plan

The Home for Little Wanderers (HFLW) operates two Community Service Agencies (CSAs) in Boston. Our CSA Development Plans are composed of multiple goals and objectives to guide our programs in achieving excellence in the delivery of intensive care coordination (ICC) and family partner (FP) services. These goals and objectives fall under two major categories: 1) continuous quality improvement and 2) work flows and communication both internally within our programs and externally with our stakeholders and Managed Care Entities (MCEs).

Continuous Quality Improvement: Our workforce is the essential strength of our services. To maintain an effective workforce it is critical that we continuously identify areas for which our staff may need additional training and support. Workforce development has always been a priority in regards to quality improvement efforts at HFLW. Significant resources are dedicated to our Workforce Learning and Development Department which provides excellent support and training to our staff. Specific to our CSA development plans, CSA staff are currently receiving training on documentation techniques to ensure that the proper hub paperwork is completed for stand-alone FP services as well as training for ensuring that our progress notes properly capture the extent of the care coordination services that are actually being provided. The goals and objectives within these training efforts have all been met or they are in progress of being met. The completion of standardized assessments and quality improvement tools are also included on our development plans. Multiple tracking strategies have been developed to assist our staff in monitoring the successful completion of these tools. Our CSAs continuously meet and document the successful completion of at least 80 percent of the required initial and reassessment of the CANS tool. Additionally, in our efforts to ensure the quality of our care planning teams, HFLW has successfully completed all required TOMs assessments. HFLW values the TOMs assessment as a quality improvement tool for our Wraparound services and we will continue to meet our target goals every year.

Work Flows and Communication: As with any strong partnership, communication is a key factor for success. HFLW leadership, program directors and program management staff are strongly supervised on this concept and it will continue to be a goal on our own CSA development plans for the future. In fact, our Senior Director of Community and Behavioral Health Services has arranged weekly, and now monthly "check ins" with our MBHP partners.

This monthly meeting is designed to improve communications by setting aside designated time to proactively identify and problem solve the inevitable challenges and barriers that present themselves in the daily operations of two CSAs. Multiple MBHP staff participates in the check in, including the Regional Director, who shares the same commitment to strong and transparent communication. In addition, and specific to our CSA development plans, our goals and objectives include our commitment to submitting a draft development plan 10 days before our scheduled meeting with the MCEs as well as goals for timely and accurate MABHA Access reporting. These goals are ongoing.

In addition to ensuring successful communication and work flows with our external stakeholders, HFLW also has goals and objectives for improving internal communication to help us problem solve critical components of program management. These goals include timely access to our services, development of a robust system of care (SOC), and the management of our efforts to not have a wait list for services. Our CSAs have instituted successful workflows and protocols in our development plans to achieve these objectives including 1) contact with families referred within 24 hours and then weekly contact until assignment 2) dedicating a staff person in each program to manage referrals and ensure timely access to our services, 3) regular outreach and solicitation for attendance at our SOC meetings, and last but not least 4) ensuring that intakes, discharges, and all development plan objectives and deliverables are standing agenda items in our weekly program leadership meetings.

B. Specific examples of strengths and needs of HFLW

Both Community Service Agencies have significant language capacity that reflects the composition of communities we serve. The families that our CSAs work with speak numerous languages and come from cultures that are not familiar to many outside of the communities that they live in. It has been and will continue to be a high priority to recruit and retain employees who represent the culture and the communities that we are working with. To accomplish this we utilize specific recruitment protocols and give a higher pay differential for experience and language. Our CSA language capacity currently includes Haitian Creole, Vietnamese and Spanish.

HFLW's commitment to training and supporting our CSA workforce results in significant strengths around specialty among the CSA staff. Specific examples of this include specialty training in early childhood mental health, specific training for Wraparound services for transitional age youth, and trauma informed training in specialty practices such as ARC and GROW.

With the proposed additions to our staff in recruitment and training we believe we will be able to recruit, train and retain our workforce with a more concerted effort.

Lastly, our existing successful partnerships with other providers in our communities are a noteworthy strength of our service provision model. Our CSAs have established referral protocols with Community Health Centers, such as Codman Square Health Center and Dorchester House, as well as specialized partnerships working with incarcerated fathers soon to return to their communities from the Suffolk County House of Corrections.

Communication, relationships and a willingness to partner with our community stakeholders are the cornerstones of our CSAs' strengths. One area of need is the funding to support the technology infrastructure necessary to make our work more efficient and accessible for our families. We believe that using the DSRIP dollars to equip our workforce with state of the art technology will build on our existing strengths and improve the quality and access to care

coordination services for our families. The existing gap in technological infrastructure often slows down our work and makes us less efficient. The business of effective and timely care coordination is now largely based in an organization's ability to leverage technology to perform services in one day that otherwise would have taken 5 days in the past. HFLW needs the proposed technology in this response to build on our strengths and continue to be a leader in effective and timely care coordination services.

C. HFLW's plans for improving timely access to ICC services

With the help of a dedicated recruiter we believe that we will be able to reduce the time to fill staff vacancies which will allow for our CSAs to work with more ICC involved families in a timely manner. The technology enhancements that we are proposing to implement will result in to time saving efficiencies and better access to services. The ultimate outcome from these efficiencies won't be limited to time savings, but that it will significantly reduce the amount of time cases stay open due to stronger client engagement. In the spirit of the Wraparound philosophy, up to date technology utilization will make it exponentially easier for a family to manage their own provider team, thus limiting the need for an ICC. Once families have been familiarized with how to use the technology such as the client portal they will eventually become their own care coordinator. Creating a tool that makes care coordination simpler not only empowers families but will reduce the amount of time cases are open allowing increased capacity for our CSAs to take more cases and creating increased capacity for families on wait lists which will result in lesser cost to the Commonwealth.

D. HFLW's plans for improving care coordination, care planning, and care management for ICC-Engaged Members

Our CSAs are experienced in wrapping around families to plan, coordinate and manage their care within HFLW network of services and among the providers involved in the children and their families' care. We intend to tackle the technological and logistical challenges that surround effective care coordination. The proposed technology enhancements including but not limited to purchasing of hardware and software and boosting functionality in our electronic health record will significantly increase efficiencies and will allow all members of the care team to communicate, cooperate, and coordinate care for each ICC-enrolled Member to deliver the best care possible. The dedicated training staff resource will support both CSA programs in ensuring that our workforce is receiving the proper training and on the job coaching to deliver High Fidelity Wraparound to improve care coordination, care planning, and care management for ICC-engaged members.

E. HFLW's plans to improve performance on quality scores and Development Plan goals

We anticipate that the updated technology available to our workforce will contribute to improvements in performance quality score and CSA development plans. Both continuous quality improvement and work flows and communication domains in our development plans will be addressed even further as we equip our workforce with user friendly, state of the art technology that will enable our workforce to complete their documentation in a timely and efficient manner. The dedicated training staff person will play a significant role in performance on quality scores and Development plan goals; working closely with the CSA leadership. The

trainer will evaluate current practices with the program leadership, make recommendations and will work with the program leadership to put the necessary trainings and supports in place.

F. HFLW's plans for improving coordination with pediatric primary care and other physical and behavioral health care providers across the care continuum for youth

HFLW is committed to improving coordination with pediatric primary care and other physical and behavioral health care providers across the care continuum for youth. Our CSAs formed a number of strategic working relationships with community providers in the recent years in anticipation of the changing healthcare environment. The technology enhancements proposed in this response will strengthen already existing relationships and will foster efficient working relationships with other providers.

Section 6.3 Populations Served and Community Engagement

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G. Member populations and communities it serves

HFLW Community Service Agencies (CSAs) provide Intensive Care Coordination to children and their families in the greater Boston area who live in the neighborhoods of Dorchester, South Boston, Hyde Park, Roslindale, Jamaica Plain and other surrounding towns. Children who are eligible for this service either currently have a Serious Emotional Disorder (SED) or have had one within the past year of their life. Typically the SED contributes largely to functional impairment in the home, school or community. Functional impairment is defined as difficulties that substantially interfere with or limit the youth in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills.

The children who qualify for ICC services typically receive multiple services from private and or public community providers such as outpatient behavioral health clinics, community health centers, primary care centers, the Department of Public Health, special education services facilitated by the Department of Elementary and Secondary Education, Department of Children and Families and or Family Resource Centers and thus need a care coordination team to ensure timely, non-duplicative , and effective services.

Referrals for ICC services come from a large continuum of community partnerships that we have established over the last several years. HFLW has a centralized intake system as the primary access point for all of our community based services including ICC. Intake coordinators and other supervisory staff within the CSA respond to the referral source and family within 24 hours. Our partners value our service and rely on us to be responsive and organized in our communications with them about a referral.

B. Relationships within the community it will leverage to improve the quality of ICC services

For the last three years HFLW has made targeted efforts to improve referral and engagement practices to ensure the ease of access, in some cases same day, to our intensive care coordination services. These efforts have occurred in the context of continuous development of partnerships and collaborations with community providers as we have worked together to meet the principal characteristics of successful integration and coordination of services for children, including a) improving client experience and b) ensuring successful engagement upon referral by breaking down barriers to obtaining services.

The number of important working relationships formed over the years with our community partners are too many to mention here. They range in concept from formal memorandum of understandings with Community Health Centers and Behavioral Health Organizations to access our services, to consultations to public health agencies on developing best practices for creating an effective, trauma informed system of care for young children.
Specific examples of the existing partnerships that we will leverage to continue to improve Care Coordination services are as follows:

Codman Square Health Center and Dorchester House: HFLW has partnered with the Codman Square Health Center for the last two years to enhance access to ICC services for patients who present in the primary care setting with physical ailments and also have a serious emotional disturbance that is causing functional impairment. The partnership allows our CSA to have an exclusive relationship with the behavioral health department at the health center to support integrated care and service delivery. In addition, our CSAs are replicating this model with the Dorchester House Multi-Service agency where we are currently hiring Intensive Care Coordinators and Family Partners who will work exclusively with their Health Center. HFLW anticipates being able to leverage these existing relationships with Codman Square Health Center and Dorchester House to expand this model to other Health Centers in an environment of Accountable Care.

Boston Public Health Commission: Both the Early Childhood and Trauma Response divisions within the Boston Public Health Commission have collaborated, and continue to collaborate, with our CSAs to train our staff and jointly develop best practices of care for the populations we serve. HFLW will continue to nurture this relationship as we further our shared vision of providing trauma informed care coordination to our vulnerable population.

Department of Education and Boston Public Schools: Members of our CSA leadership participate in the Boston Public School Behavioral Health Collaborative. This is a high level, monthly meeting of providers, DMH, and BPS administrators aimed at developing best practices and therapeutic interventions that generate measurable outcomes in the Boston Public School System. Additionally, our CSA staff provides regular consultation to multiple schools within the BPS system including the Dever-McCormick K-8 School and at all three sites of the McKinley Schools. These consults facilitate improved access to our intensive care coordination services for students as well as referral to other community providers to address the complex needs of these students.

Family Matters: HFLW has a unique partnership with the Suffolk County House of Corrections. In this model our CSA co-locates an intensive care coordinator inside the prison once a week to begin the process of engaging men who are fathers and are preparing to return to the community. This model is designed to engage fathers as soon as possible and ideally before they are released from prison, so that our care coordinators can begin the process of building a team around the child as their father prepares to return home. This is an excellent example of creative and targeted efforts that HFLW has made to increase access to a vulnerable and underserved population.

Specialty programming and culturally competent care coordination services: Our CSAs have significant language capacity and cultural competency to serve the Vietnamese community in Boston. The Boston Chinatown Neighborhood Center, the largest social service provider for Asian families in Boston attends our monthly system of care (SOC) meetings where we discuss system integration and challenges. We make and receive referrals to/from this organization. We also have a unique referral relationship with the Federation of Children with Special Needs that support families with navigating special education process within Boston Public Schools. Vietnamese-speaking staff from the Federation refers exclusively to HFLW because of the language and cultural competency within our CSAs.

System of Care (SOC): To ensure that we are successful in our efforts to improve the quality of care through collaboration with providers, we will continue to recruit for and facilitate monthly system of care meetings in the community. These meetings allow us to access and understand the needs and strength of the system integration efforts in the communities we serve. Current membership in our SOC meetings is robust with representatives from the following agencies:

- Departments of Mental Health and Children and Families
- Caring Together
- Department of Youth Services (Clinical Director)
- Private provider community including Bay Cove Human Services, Mass Mentors, Adoption Journeys, South Bay Mental Health, Silver Lining Mentoring, Lena Park Center, Best team, Clergy
- The Institute for Health and Recovery

C. How the current and planned partnerships align with the proposed project(s)

The existing partnerships and community collaborations outlined above demonstrate our CSAs' commitment to excellent care coordination for all children and families. We believe that the existing partnerships we have with the aforementioned community health centers will enable us to pilot the proposed EHR enhancements with these partners. , our collaborative working relationships with providers with specific population focus such as The Boston Chinatown Neighborhood Center will afford us unique opportunities to pilot and receive feedback on how utilization of certain technologies meet the needs of the diverse populations we serve. We will build upon lessons learned from these small pilots to refine the scope of our work with larger ACOs to coordinate care in the most efficient manner possible. Our long term vision is to be able to communicate and coordinate care with all partners involved in a client's care via most up to date technology that will enable the child's care team community to see "the whole child" rather than focusing on a particular aspect of their treatment (i.e.: Individualized Education Plan, Occupational Therapy, medication management, etc.).

Section 6.4 Proposed Project(s) and Investment Plan

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A. Project description (program narrative)

Abstract
The Home for Little Wanderers (HFLW) is proposing a technology upgrade project to be carried out in both Community Service Agencies it operates: Hyde Park and Park Street. The main goal of this project is to implement technology improvements to strengthen integration with all providers involved in ICC enrolled members' care. We anticipate that these proposed enhancements will also strengthen fidelity to the Wraparound model and improve member engagement. The project will result in enhancements in HFLW's existing electronic health record, purchasing and setting up tablets for ICC staff to use in the field,. HFLW anticipates purchasing the tablets and investing a significant amount of staff time to coordinate internally during the prep period outlined in this RFR. The consequent years will be spent making improvements in the electronic health record and ongoing implementation and support of the enhancements established by a multidisciplinary team at HFLW. The proposed deliverables are utilization of tablets by the CSA staff to aid in high fidelity Wraparound service provision, providing all ICC enrolled clients and caregivers with a Client Portal, and Care Plans embedded in HFLW electronic health record. DSRIP funding will be used to purchase tablets and pay for enhancements to our EHR. The project team will consist of Director of Health Information Systems, Senior Director of Behavioral Health, and the CSA program leadership. The funds will be distributed between the two CSAs based on the program size, both staff and enrolled members. HFLW plans to track time between referral and enrollment, hospitalizations and ER visits during ICC enrollment, and change in caregiver skills over time.

The Home for Little Wanderers Community Service Agencies Client Centered Care Coordination Project
HFLW is proposing technology enhancements focusing on client centered care to accomplish strong integration with ACOs and primary care providers. Over the course of the next 5 years, HFLW is aiming to a) equip our workforce with the state of the art technology to effectively manage and coordinate care with a team of community partners composed of all providers involved in a client's care, b) improve member engagement by leveraging technology to empower clients and caregivers to manage their own care plan c) imbed ICC care plans in HFLW's electronic health record, and d) improve member engagement including strengthening fidelity to Wraparound via a client portal.

HFLW believes that the changing landscape of healthcare in the Commonwealth make it a necessity for providers to find efficient cost saving ways to manage and coordinate care. Within this context, leveraging technology to improve care management and care coordination efficiencies has been a priority for HFLW CSAs in the recent years. HFLW made significant strides in advancing our technological infrastructure to adapt to the new ways of providing and coordinating care. We applied for, and was selected to, participate in the eQuality Incentive Program (eQuip) sponsored by the Massachusetts eHealth Institute (MeHI). The most significant accomplishment of this project was HFLW's successful bidirectional connection to the Mass HIway (HIway). Through the DSRIP funding, our main goals are to maximize the utility of Mass HIway, make enhancements in our electronic health record system (NetSmart's Evolv), and equip our workforce with the most up-to-date software and technology that will allow them

to serve the children and families enrolled in ICC services. These major improvements will have a positive impact on HFLW CSAs' Development Plans, as well as the goals outlined in this RFR.

HFLW anticipates engaging in a series of activities to accomplish the goals described above. We anticipate that some of the activities outlined in this section will be carried out simultaneously and others will be sequential, building upon the execution of other activities described. The technology improvement activities are as follows:

- Capturing primary care provider in HFLW electronic health record: Primary care provider information recorded in HFLW Evolv system is the first necessary step for the capability to exchange information with ACOs and primary care providers. This initial effort will set up the stage for exchanging information and coordinating care.
- Making enhancements and changes in Evolv to allow for seamless electronic communication and collection of additional data points: In line with the quality measures described in Attachment A of this RFR, HFLW desires to capture ICC member hospitalization and ER visit (as related to a behavioral health matter) information in Evolv in a format that easily allows for program leadership and senior leadership to run reports to help inform our practice.
- Equipping the CSA workforce with Microsoft Surface Pro Tablets: HFLW intends to purchase and set up tablets for all CSA ICC staff to use in the field. Equipping our workforce with this mobile and highly efficient technology will enable HFLW to accomplish several goals. First, the live electronic signature capability in the tablets will allow for staff to gather necessary signatures from parents/guardians and other providers during meetings, increasing the fidelity to Wraparound practices around family-driven practice. Another benefit of the tablets in strengthening family-driven practice will be through the utilization of assessments. The tablets will facilitate more efficient administration of the Caregiver Skills Assessment that is currently a part of the electronic health record. This assessment allows our staff to focus on each caregiver's unique strengths and needs.
- Care Plan built into electronic health record: The CSA Care Plan is a specific, standardized, document utilized in all CSAs in the Commonwealth. As a unique document, the form itself does not exist in generic medical records such as Evolv. The CSA Care Plan will be embedded into Evolv by our IT department which will enhance our ability document and pull important aggregate data from the health record.

The anticipated deliverables of the proposed project are as follows:

- Primary care provider information for all ICC members enrolled after put after the budget period will be recorded in Evolv.
- Each CSA staff will have an agency-issued Microsoft Surface Pro tablet.
- Care Plans will be embedded in Evolv.

The DSRIP funding will be used to enhance our use of technology to improve the quality of care coordination services and member experience. Specifically, the funds will allow HFLW to 1) purchase tablets and design technology, 2) improve our EHR functionality through system enhancements

HFLW has robust IT and electronic health record departments that continuously support both Hyde Park and Park Street CSAs. Members of these departments will be engaged on the proposed project. We will rely heavily on our IT and electronic health record experts specifically

our Director of Health Information Systems who will invest their time, knowledge and skills. Additionally, our Senior Director of Community Services and Behavioral Health has extensive experience and knowledge of developing accountable care systems and structures in the State of Maine where he participated on multiple provider- and state-lead committees tasked with developing a new system of care under the Affordable Care Act between 2010 and 2013. Furthermore, CSA program directors and the supervising program director for Park Street CSA will oversee the day to day implementation of the aforementioned enhancements at the program level, ensuring the optimal utilization of the hardware and software to make this project a success.

The available funds will be allocated based on staff size and number of enrolled clients. CSA staff size will determine the number of tablets purchased. Total number of ICC enrolled clients in each site will determine the funds distributed since the payments are structured by number of ICC enrolled members.

HFLW is committed to ongoing program evaluation and outcomes measurement. HFLW has a dedicated Risk Management, Evaluation and Outcomes (RMEO) department that organizes, analyzes and reports on many programmatic activities at the organizational and program level. Throughout the year, the RMEO department provides support, monitors processes and outcomes, and analyzes data gathered at the program level. For the CSAs, RMEO currently tracks, analyzes and reports on the characteristics of families served, discharge outcomes, Caregiver Skills Assessment results, satisfaction survey feedback, and the results from The Home's post-discharge follow-up interviews. Additionally, CSA leadership and RMEO senior staff discuss WIFI and TOM results as they are published every year to identify areas of strong Wraparound practice and areas that may require quality improvement activities. Program leadership and RMEO staff will continue to collaborate on measurement to ensure that program activities and process outcomes are leading to the desired client and programmatic outcomes.

Over the course of the project, the CSAs will continue to utilize TOM to assess fidelity to high quality wraparound practice. We anticipate that the technology enhancements will enable the following:

- Tablets will give greater access to complete assessments (such as CANS, caregiver skills assessment, etc.) during the course of home visits
- Families will be able to sign off on assessments and plans during home visits, thus ensuring staff are integrating family voice and choice
- Tablets and custom fields in the electronic health record will make it easier to review progress by looking at assessments and plans in real time
- Levering technology will assist with the ongoing use of outcomes data to inform decision making, which is part of evidence-based practice
- Imbedding ICC care plans will enable individualized care planning

When the above changes in practice are implemented, and based on our most recently available TOM scores, we anticipate that by Budget Period 3 both CSAs will show 25% improvement on the "Based on Priority Needs" and 20% improvement on the "Outcomes Based Processes" domain scores.

"Based on Priority Needs" domain measures to what extent the needs of the child and family are prioritized and how the needs are addressed. The items in this domain include

- Before beginning to brainstorm strategies, the team explicitly articulated, prioritized, and/or reviewed and confirmed the youth's and family's needs to plan for/address during the meeting.
- Every need that was planned for/addressed during the meeting was articulated as the underlying reason(s) why a problematic situation or behavior was occurring, and was not simply stated as a deficit, problematic behavior, or service need.
- Planning focused on the underlying needs of other family members, not just the identified youth.
- For every need that was planned for/ adressed during the meeting, the team brainstormed more than one strategy to meet the need before deciding on next steps.
- The team discussed how they will know the youth and family's needs have been sufficiently met to warrant a transition out of formal Wraparound services.

"Outcomes Based Processes" domain measures whether the Wraparound practice is goal oriented and includes measurable goals. The items that measure this domain include

- The team reviewed how close the youth and family are to achieving their vision, mission, or Wraparound team goal.
- The team reviewed the status of task/action step completion since the last meeting.
- The team monitored progress toward meeting needs and achieving outcomes/goals since the last meeting.
- Progress toward meeting needs and achieving outcomes/goals since the last meeting was evaluated using objective and verifiable measures, not just general or subjective feedback.
- For any new outcome or goal developed during the meeting, the team discussed and agreed upon as specific and measurable way to evaluate progress.

In Budget Year 1 TOM will be conducted by the Program Directors then the responsibility will gradually shift to the Wraparound Trainer. By Budget Year 3, data collection will be completed by the Wraparound Trainer. Program leadership, the Wraparound Trainer, and RMEO will work collaboratively to analyze report and summarize the results.

• B. Project Team Description

1. Organizational chart

Please see Attachment 6.4B-1.

2. A list of current staff that the Bidder proposes will be involved in the project(s), including their job descriptions and qualifications for the project(s)

The project team will consist of the following HFLW staff: Andrew Massey, Director of Health Information Systems; Matthew Small, Senior Director of Community and Behavioral Health Services; Natalie Sheehan-Dias, Supervising Program Director; Raechelle Joyner, Program Director of CSA Hyde Park; Kathleen Irving, Program Director of CSA Park Street.

Resumés and Job Descriptions are enclosed in Attachment 6.4B-2.

Andrew Massey has over ten years of experience in the human services informational technology field. Since starting his current position at HFLW, Andrew made significant enhancements in HFLW electronic health record possible (i.e.: conversion from ICD9 to ICD10 and implementation of electronic treatment plans). He will bring technical expertise and network & system administration skills to the project team and will act as the key staff in exploring and implementing care coordination software.

Matthew Small, an Independently Licensed Clinical Social Worker, has over twenty years of experience in child welfare and behavioral health fields. Since 2013, he has overseen the operations and administration of a large scale continuum of behavioral services, including CBHI services. Matt provides oversight, leadership and supervision to 11 program directors with more than 20 million dollar operating budget. As aforementioned, he is experienced in service delivery systems change and will serve as the implementation team leader on the programmatic side.

Natalie Sheehan Dias is an Independently Licensed Clinical Social Worker with over twenty five years of experience dedicated to working with children and families in the Greater Boston area. For the past seven years, Natalie has been intricately involved in the acquisition, development, and implementation of services through the Children's Behavioral Health Initiative. She currently serves as the Supervising Program Director of the Dorchester/South Boston Community Service Agency and Boston Safe-at-Home program of HFLW. In this role and with the support of The Home, Natalie has established partnerships with other agencies and institutions, working to make significant, effective changes in the community through integrated, comprehensive service delivery systems.

Raechelle Joyner is an Independently Licensed Clinical Social Worker who has worked with underserved populations and communities for over twenty-three years. Throughout her twenty years of service at HFLW, she has worked in Nursing, Foster Care and Adoption, Family Stabilization, Community Support, and Outpatient Therapy. She currently serves as the Program Director of the Hyde Park Community Service Agency, overseeing the day-to-day operations and administration of all aspects of programming including the CSA development plan implementation. Raechelle holds a certificate from the Eikenberg Institute for Relationships in Multicultural Supervision and has graduated from the Institute for Nonprofit Practice at Tufts University. She simultaneously works as an Adjunct Professor at Wheelock College and teaches three core bachelor level courses. She was given the Outstanding Field Instructor Award by Wheelock College for her work in promoting human rights and social justice.

Kathleen Irving is an Independently Licensed Clinical Social Worker with ten years of experience working with children, families and adults in a multitude of mental health settings. Kathleen's focus has been in community based mental health, beginning as a family therapist and moving into supervisory, training and program leadership roles at HFLW. She currently serves as the Program Director of the Park Street CSA overseeing the day-to-day operations and

administration of all aspects of programming including the CSA development plan implementation. She is experienced in health care innovation and care integration with behavioral health and Emergency Room services.

3. Any staff the Bidder proposes to hire or engage to be involved in the project(s), including their proposed job descriptions and qualifications for the project(s)

HFLW does not plan to hire additional staff for this project.

4. The roles and responsibilities of each staff of the Bidder's Project Team and how the Bidder will ensure efforts are coordinated among staff and not duplicated

Since the inception of Children's Behavioral Health Services, HFLW has made significant efforts to work collaboratively with internal and external stakeholders to integrate CSA and in home therapy (IHT) services with larger initiatives in the city of Boston. These collaborations have included projects designed to integrate and co-locate ICC and FP services within Community Health Centers, consultation with The Boston Public Health Commission Project Launch and Early Childhood System of Care initiatives, and embedding Intensive Care Coordination within the Suffolk County House of Corrections to facilitate immediate access to services for men being released from prison and returning to their families.

The efforts mentioned above are just a few examples of the leadership role that HFLW has played within the larger system of care in Boston over the past several years. In that light, to ensure targeted communication and to minimize duplication of efforts, the following team has been assembled.

The Senior Director of Community and Behavioral Health, in addition to the defined responsibilities in his job description will:

- Chair the monthly DSRIP implementation meetings
- Define the project teams action plan and be responsible for ensuring each members deliverables
- Attend statewide MassHealth conferences and information sessions
- Be the lead liaison to MassHealth and other payor entities

Supervising Program Director's responsibilities will include:

- Act as the lead CSA liaison to the project team
- Ensure uniform implementation of Care Planning across HFLW programs
- Participation in monthly EHR Committee meetings
- Participation in monthly DSRIP implementation meeting
- Attendance at the Children's Services Association of Behavioral Health meetings
- Conduct trainings at CSA staff meetings on updated workflow procedures for ICCs needed.

CSA Program Directors, in addition to their programmatic roles, will:

- Participate in monthly DSRIP implementation meetings

- Coordinate and lead test groups within their programs designed to pilot changes to practice procedures and the EHR before full implementation
- Report findings of the pilot/test groups to the project team
- Attend EHR Committee meetings as needed

Director of Health Information Systems, in addition to his current role and responsibilities, will:

- Participate in monthly DSRIP implementation meetings
- Chair the EHR Committee and invite project team members as needed
- Design electronic workflows that achieve the objectives of the project
- Upload existing State mandated CSA documentation into our EHR
- Attend Conferences and Trainings on ACO and MCO negotiation

5. A description of how the Bidder proposes to manage the project(s).

HFLW Client Centered Care Coordination Project will be lead and managed by our Senior Director of Community and Behavioral Health Services. The Senior Director is responsible for the operations of all our community based programming at HFLW, including both of our CSAs involved in this project. In this capacity, supervisions and operational workflows have been established that allow for the successful completion of multiple projects at any given time. Specific to the DSRIP project, the Senior Director will convene an additional monthly project team meeting where timeline and the corresponding deliverables will be assigned, reviewed and updated. The Senior Director will also work closely with the Director of Health Information Systems to ensure efficient workflows during roll out of new technology.

C. Implementation Plan and Timeline

Time Period	Anticipated Implementation
January 2018	Finalize contracts with EOHHS
February 2018	Establish data fields in our EHR for PCP information and process for staff to record PCP information (name, organization, phone/fax/email, ACO affiliation, connection to MassHIway, their EHR product); Explore purchase of care planning software
March 2018	Purchase and set up tablets; start collection of PCP information in EHR
March 2018	Create training for ICCs on use of tablets and test electronic signature capabilities; continue PCP information collection
March 2018	Implement training for ICCs on use of tablets and electronic signature capabilities; continue PCP information collection
April 2018	Implement training for ICCs on use of tablets and electronic signature capabilities; continue PCP information collection
May-July 2018	Imbed ICC care plans in our EHR record; Determine health information wanted from PCP (diagnosis, treatment plan, meds, etc.)
August-Nov. 2018	Imbed ICC care plans in our EHR record; Imbed medial health information from PCP into our medical record;

1Q Year 2	Imbed ICC care plans in our EHR record; Imbed medical health information from PCP into our medical record; train staff on using the care plans in EHR
2Q Year 2	Train staff on entering PCP information into the EHR; continue to train using the care plans in the EHR ; modify the forms in EHR as necessary.
3Q Year 2	Create electronic referral form for PCPs that will include basic information (demographic, diagnosis, health insurance) and reason for referral. Create an electronic PCP feedback form to include information on whether the patient scheduled and kept the appointment, and the results of the appointment (e.g. initial diagnosis /diagnostic impression, tests ordered, next steps, etc.);
4Q Year 2	Provide ongoing quality control of data input/output and processes and make adjustments accordingly.
1Q Year 3	Provide ongoing quality control of data input/output and processes and make adjustments accordingly.
2Q Year 3	Provide ongoing quality control of data input/output and processes and make adjustments accordingly.
3Q Year 3	Provide ongoing quality control of data input/output and processes and make adjustments accordingly.
4Q Year 3	Provide ongoing quality control of data input/output and processes and make adjustments accordingly.
1Q Year 4	Provide ongoing quality control of data input/output and processes and make adjustments accordingly.
2Q Year 4	Provide ongoing quality control of data input/output and processes and make adjustments accordingly.
3Q Year 4	Provide ongoing quality control of data input/output and processes and make adjustments accordingly.
4Q Year 4	Provide ongoing quality control of data input/output and processes and make adjustments accordingly.
1Q Year 5	Provide ongoing quality control of data input/output and processes and make adjustments accordingly.
2Q Year 5	Provide ongoing quality control of data input/output and processes and make adjustments accordingly.
3Q Year 5	Provide ongoing quality control of data input/output and processes and make adjustments accordingly.
4Q Year 5	Provide ongoing quality control of data input/output and processes and make adjustments accordingly.

- **D. Budget Report and Budget Narrative**

Please see Attachment 6.4D.

- **E. Sustainability**

As aforementioned, HFLW has robust administrative departments that support our behavioral health programming. As one of the largest behavioral health providers in the Commonwealth, generating more than 50 million dollars in claims annually, HFLW has an existing sustainable administrative infrastructure to guide us through every stage of complex project implementation.

Specifically, HFLW will utilize existing meeting structures as tools for a) determining capital expenditures and b) determining and resourcing strategic initiatives. Membership at these meetings consist of executive level leadership and key project leaders who report directly to the CEO and ultimately the Board of Directors. The DSRIP contract, and the associated strategic decisions and capital expenditures that will be developed further, evaluated and fully vetted by these groups. It is thru this process, as well as our newly developed monthly project meetings, that a sustainable financial plan will be established to ensure that our staff have access to state of the art tools, both in the now and in the future, to help us achieve our mission

- **Our plan to leverage the DSRIP funding to continue the enhancement of our technological infrastructure by purchasing items such as tablets, paying for administrative staff time to roll out the devices to program staff will be invaluable as we prepare to do business in an accountable care environment.**

Section 6.4 Proposed project(s) and Investment Plan

Abstract

The Home for Little Wanderers (HFLW) is planning on adding two additional FTEs to support our CSAs' workforce development. The two main goals of this project are to a) ensure and support the delivery of high quality High Fidelity Wraparound services via a designated training resource and b) ensuring timely access to services for ICC enrolled members by having a designated recruiter to work with our CSAs to fill open staff positions. The project will result in coordinated and centralized efforts in supporting how our CSAs deliver ICC services and recruit and retain a highly qualified workforce. HFLW anticipates hiring and onboarding the two new resource staff members during the prep period. During the first budget year these resource positions will start working with the CSA and operations leadership to develop and implement plans for workforce development. The consequent years will be spent developing, delivering and modifying training plans and continuous recruitment efforts. The proposed deliverables are a HFLW High Fidelity Wraparound Curriculum for new ICC employees, an onboarding plan for new ICC staff as well as an in-service training plan for ICC staff as part of continuing on the job coaching and training. On the recruitment side, the deliverables will be decreased length of open positions and increased number of high quality applicant pool. DSRIP funding will be used to support the salaries of these two FTEs during the prep and budget year 1 periods as well as sign on bonuses for ICC staff. In consequent years, HFLW will start absorbing the salary cost gradually with the understanding that a strong workforce yields cost savings to the agency by decreasing turnover. In addition to the two staff proposed, the project team will consist of Senior Director of Behavioral Health and the CSA program leadership. The funds will be distributed between the two CSAs based on the program size, both staff and enrolled members. HFLW plans to track duration for open positions, time between hire date and completion of onboarding and number of staff completing in-service trainings.

The Home for Little Wanderers Community Service Agency Workforce Development Project

The Home for Little Wanderers fully acknowledges that better care coordination and integration with ACOs hinge on the delivery of High Fidelity Wraparound by qualified and trained staff. In order to bolster our workforce, HFLW is proposing to add two full time staff to support our CSAs' workforce development: One recruiter as a staffing resource and one trainer as Wraparound practice support.

Given the current employment environment in the Commonwealth, we recognize that we must have a targeted strategic recruitment plan to keep both of our CSAs fully staffed so that we can provide timely access to ICC services for eligible children and their families. Attracting and hiring the top talent is the first step in developing a workforce who is able to deliver high quality services. Currently we have several open positions in our CSAs; some of which have been waiting to be filled since May. Two major factors have strained HFLW's recruitment and staffing resources: Current low unemployment rates in the Commonwealth and generational turnover in the workforce in the United States. With Baby Boomers retiring at high rates and more and more millennials entering the job force every day; we are looking into ways in which

we need to adapt to the changing landscape of talent management. Given these challenges and our existing resources, the workforce development aspect of the DSRIP funding is very timely. These funds will allow us to hire a full time recruiter who will work closely with our CSA program leadership to fulfill the programs' needs.

Efficient recruitment is only the beginning phase of building a healthy and strong workforce. We fully recognize that recruitment goes only so far without the appropriate training, support and coaching that happens upon hire and during an employee's tenure at HFLW. Continuous in-service training and on the job coaching are among the most commonly cited factors for keeping a healthy workforce as well as reducing turnover. HFLW's Workforce Learning & Development department delivers a comprehensive two day new employee orientation to all new hires. When staff starts their employment in their respective programs, the program specific training and on boarding is handled by the program leadership. Currently, the CSA program directors deliver these trainings which take them away from their responsibilities of day-to-day management of the programs. A dedicated High Fidelity Wraparound training support staff is needed to standardize the training and support staff receives both upon hire and on an ongoing basis..

Project Scope

The workforce development project proposed in this application will be a comprehensive team effort on streamlining and strengthening efforts to build and maintain a robust workforce that delivers High Fidelity Wraparound services to children and families. Two main pillars of this effort are recruitment and training. As aforementioned, HFLW as an agency has the structure in place to recruit, hire, and train staff; however the current employment market and the changing landscape of talent management has strained our existing resources. We are finding that we need to add additional resources to our structure to support our CSAs.

Recruitment

The recruiter will initially be responsible for creating a comprehensive staffing strategic plan that is specific to the CSA workforce. Upon hire, the recruiter will work with the project team that includes Senior Director of Behavioral Health and the CSA program leadership to review the current practice and procedures, including job descriptions, the screening and interview process and will review CSA turnover data. Upon completion of the plan, the recruiter will take the lead in implementing the staffing strategic plan with short and long term recommendations that will arise from the plan. In addition to the planning activities, the recruiter will simultaneously review resumes and screen candidates; gradually taking over the responsibilities for the full process. Currently, the Program Directors interview the candidates. Another crucial aspect of sustainable high quality candidate pool is relationship building and marketing the exciting roles and responsibilities of the open positions on an ongoing basis. During periods of high vacancy/high number of candidates, the Program Directors do not always have the resources to be able to keep candidates engaged. The recruiter will also be responsible for keeping a list of contacts and establish a professional network where HFLW can utilize as a sustainable candidate pool. The recruiter will attend key events such as conferences and school events to cultivate strategic relationships. We envision our newly created CSA recruiter position to be filled by an individual either knowledgeable of Wraparound practices or have the skill sets to learn and understand the spirit behind High Fidelity Wraparound overall to be able to market the open positions properly.

Training and Support
As aforementioned, the Wraparound specific training currently occurs at the program level, delivered by mainly program leadership. Our CSA program directors have taken the initiative to develop trainings derived from Wraparound manuals. In addition, program leadership TOM staff and provide coaching at a minimum twice a year. The vision for this new trainer position is to take over the program training responsibilities, develop additional trainings, ensure proper utilization of the training resources Mass Health is announcing to make available, and serve as a coach to the program staff to increase the frequency of coaching staff receive both upon hire and as ongoing regular in-service support. The trainer will be responsible for ensuring staff complete the trainings provided by MassHealth and develop more advanced training modules. Please note that this is a new position that is being created through the DSRIP grant. Upon hire, the trainer will work with the project team to assess current training practices and develop a comprehensive training plan for both CSAs. The expectation is that the trainer will develop a plan and a curriculum. The trainer will work with Mass Health to determine the specific training modules integrated into our curriculum. The trainings developed will include advanced topics such as Managing to Quality (for supervisors) and Engagement with Specialty populations (i.e.: aging out, incarcerated parents)

The Wraparound trainer will also be expected to take over the completion of TOMS. This will ensure we are *evaluating our staff without the bias that can occur when done by a supervisor within the program. This is a significant task as they would need to do about 4 per month for both programs; including 2 hours per TOM observation meeting, and then another hour post of debrief and coaching to that staff and their supervisor.*
Currently, on the job coaching is a significant challenge for our CSAs to provide. Having a dedicated resource for this function will ensure that every staff has access to coaching resources as needed. In addition to one on one coaching, the trainer will be tasked to support supervisors in supervision and coaching aspects of their role so that our CSAs can build capacity to support the workforce they are tasked to manage.

Proposed deliverables The initial major deliverable for the recruiter will be the staffing strategic plan that outlines recruitment and retention strategies and benchmarks. Implementation of milestones within that plan will be monitored by the Senior Director of Behavioral Health. Additional deliverables for the recruiter will be regular participation and presentations at recruitment events and conferences, establishing and maintaining a high quality candidate pool. On the training side, the major deliverable will be the comprehensive training curriculum. Additional deliverables are regular completion of TOMS, implementation of a regular coaching schedule, and a training series for supervisors on supporting their direct reports specifically around Wraparound practices. .

Use of DSRIP funding

The DSRIP funds will allow HFLW to build capacity in the workforce development domain. The funds will support the salary, tax and fringe of these two new hires in the first full year of their employment. After the first year, the DSRIP funds will be allocated gradually less over time and the HFLW agency budget will absorb these costs. Supporting the salaries of two new positions will directly help HFLW accomplish goals 2 and 3 under 3.4 of this RFR. In addition, we are proposing to spend a portion of the funds on sign on bonuses. Currently, HFLW offers sign on

bonuses to highly qualified candidates to attract best talent while keeping our salary structure intact. Funds in the proposed budget will be utilized to support the recruitment efforts.

Existing internal resources

Our existing Program Operations team, CSA leadership, HR and the new positions created through DSRIP funds will work collaboratively to make this a success. Last year, HFLW engaged a multidisciplinary internal turnover workgroup to analyze HFLW data on turnover trends and human resources needs. The team set forth a number of recommendations to the Executive Management Team. HFLW, at the agency at large level, is in the process of implementing a turnover plan. The proposed Workforce Development plan will benefit from these larger agency efforts. In addition, HFLW has a dedicated Risk Management, Evaluation and Outcomes (RMEO) department that organizes, analyzes and reports on many programmatic activities at the organizational and program level. Throughout the year, RMEO department provides support, monitors processes and outcomes, and analyzes data gathered at the program level to support quality improvement activities. For CSAs, RMEO currently tracks, analyzes and reports on discharge outcomes, Caregiver Skills Assessment results, and satisfaction survey results. CSA leadership and RMEO senior staff will continue to collaborate on tracking and reporting processes and outcomes.

Allocation of funds

Workforce development portion of the funds will be allocated according to the pay scale HFLW utilizes. These two positions will support the two CSAs in proportion to program size. Likewise, sign on bonuses will be distributed between the two programs depending on program size and the number of new hires.

Evaluation, measurement or performance management strategies

HFLW's Human Resources Department collects and analyzes data related to open positions, recruitment, staff training and turnover. The trainer and the recruiter, along with the project team will review the current data for these metrics and determine benchmarks and SMART goals on each of these domains. The goals are to a) decrease the time it takes to fill open positions by 25% by Budget Year 3, b) increase the number of hours staff receive on the job coaching by 50% by Budget year 3 c) increase the number of staff attending in-service trainings by 40% by Budget year 2 d) decrease turnover by 25% in ICC workforce by Budget Year 3. As aforementioned, the baseline and benchmarks will be established upon review of current data and establishment of work plans the trainer and the recruiter will be tasked with. The Trainer and the Recruiter will work with the Project team to track, analyze and discuss the evaluation data.

Project Team description

The project team will consist of the following HFLW staff: Matthew Small, Senior Director of Community and Behavioral Health Services; Natalie Sheehan-Dias, Supervising Program Director; Raechelle Joyner, Program Director of CSA Hyde Park; Kathleen Irving, Program Director of CSA Park Street. The Wraparound trainer position will initially sit under Program Operations and will report to the Senior Director of Community and Behavioral Health Services. The recruiter will also be a member of this project team and will engage the team in a strategic recruitment planning process. The recruiter will report to the Director of Employment services under Human Resources Department at HFLW. The resumes and job descriptions are attached. Job descriptions for the new proposed positions are attached. Matthew Small, an Independently

Licensed Clinical Social Worker, has over twenty years of experience in child welfare and behavioral health fields. Since 2013, he has overseen the operations and administration of a large scale continuum of behavioral services, including CBHI services. Matt provides oversight, leadership and supervision to 11 program directors with more than 20 million dollar operating budget. As aforementioned, he is experienced in service delivery systems change and will serve as the implementation team leader on the programmatic side.

Natalie Sheehan Dias is an Independently Licensed Clinical Social Worker with over twenty five years of experience dedicated to working with children and families in the Greater Boston area. For the past seven years, Natalie has been intricately involved in the acquisition, development, and implementation of services through the Children's Behavioral Health Initiative. She currently serves as the Supervising Program Director of the Dorchester/South Boston Community Service Agency and Boston Safe-at-Home program of HFLW. In this role and with the support of The Home, Natalie has established partnerships with other agencies and institutions, working to make significant, effective changes in the community through integrated, comprehensive service delivery systems.

Raechelle Joyner is an Independently Licensed Clinical Social Worker who has worked with underserved populations and communities for over twenty-three years. Throughout her twenty years of service at HFLW, she has worked in Nursing, Foster Care and Adoption, Family Stabilization, Community Support, and Outpatient Therapy. She currently serves as the Program Director of the Hyde Park Community Service Agency, overseeing the day-to-day operations and administration of all aspects of programming including the CSA development plan implementation. Raechelle holds a certificate from the Eikenberg Institute for Relationships in Multicultural Supervision and has graduated from the Institute for Nonprofit Practice at Tufts University. She simultaneously works as an Adjunct Professor at Wheelock College and teaches three core bachelor level courses. She was given the Outstanding Field Instructor Award by Wheelock College for her work in promoting human rights and social justice.

Kathleen Irving is an Independently Licensed Clinical Social Worker with ten years of experience working with children, families and adults in a multitude of mental health settings. Kathleen's focus has been in community based mental health, beginning as a family therapist and moving into supervisory, training and program leadership roles at HFLW. She currently serves as the Program Director of the Park Street CSA overseeing the day-to-day operations and administration of all aspects of programming including the CSA development plan implementation. She is experienced in health care innovation and care integration with behavioral health and Emergency Room services.

Since the inception of Children's Behavioral Health Services, HFLW has made significant investments in recruitment, training and retention of our ICC workforce. In addition to the initial agency on boarding and new employee orientation provided by the Workforce Learning & Development Department; the CSA leadership has been providing the initial and in-service trainings on particular Wraparound topics; as mentioned elsewhere in this proposal.

In order to streamline the training and recruitment efforts, the project team will meet on a regular basis. Both the trainer and the recruiter will work closely with CSA leadership on their respective deliverables between these meetings and provide updates. Our goal is to create the internal

capacity and the necessary structures that will allow HFLW to keep up with the training and recruitment demands the current employment market dictates.

To ensure targeted internal communication and to minimize duplication of efforts, the following team has been assembled.
The Senior Director of Community and Behavioral Health, in addition to the defined responsibilities in his job description will:

- Chair the monthly DSRIP implementation meetings
- Define the project teams action plan and be responsible for ensuring each member's deliverables
- Attend statewide MassHealth conferences and information sessions
- Be the lead liaison to MassHealth and other payor entities

Supervising Program Director's responsibilities will include:

- Act as the lead CSA liaison to the project team
- Work closely with the Wraparound Trainer to develop the curriculum
- Work closely with the recruiter to develop the strategic recruitment plan and implementation of the strategic plan
- Ensure uniform implementation of Care Planning across HFLW programs
- Participation in monthly DSRIP implementation meeting
- Attendance at the Children's Services Association of Behavioral Health meetings
- Work with the Wraparound trainer to develop trainings for CSA staff on updated workflow procedures for ICCs as needed.

CSA Program Directors, in addition to their programmatic roles, will:

- Participate in monthly DSRIP implementation meetings
- Coordinate and lead test groups within their programs designed to pilot the Wraparound curriculum developed by the Trainer.
- Report findings of the pilot/test groups to the project team

HFLW Workforce Development Project will be lead and managed by our Senior Director of Community and Behavioral Health Services. The Senior Director is responsible for the operations of all our community based programming at HFLW, including both of our CSAs involved in this project. In this capacity, supervisions and operational workflows have been established that allow for the successful completion of multiple projects at any given time. Specific to the DSRIP project, the Senior Director will convene an additional monthly project team meeting where timeline and the corresponding deliverables will be assigned, reviewed and updated. The Senior Director will also work closely with the Director Employment services to ensure efficient workflows during on boarding of the new recruiter position to the agency and to their CSA specific role.

HFLW's proposed workforce development plan timeline is as follows:

Jan-18	Develop and post job descriptions for Wraparound trainer and CSA staff recruiter	Develop and post job descriptions for Wraparound trainer and CSA staff recruiter
Feb-18	Interview candidates and hire Wraparound trainer and recruiter	Interview candidates and hire Wraparound trainer and recruiter
Mar-18	Interview and hire Wraparound trainer and recruiter. Wraparound trainer and recruiter complete new employee orientation	Interview and hire Wraparound trainer and recruiter. Wraparound trainer and recruiter complete new employee orientation
Apr-18	Trainer conducts assessment (interviews/observations) on current use of Wraparound model and reviews TOMs reports	Recruiter evaluates current process for recruiting CSA staff including sources of recruitment, job descriptions, interview process, offers, background checks, etc. and reviews CSA staff retention data; interviews CSA supervisors/leadership and staff and trainer regarding retention issues.
May-July 2018	Trainer develops Wraparound training and schedule for existing and new staff, TOM implementation schedule; and a plan for reviewing aggregated TOM results for improvements to staff training and development.	Recruiter develops comprehensive recruitment and retention plan, which includes short and long-term strategies for CSA staff development and growth
August-Nov 2018	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations
1Q Year 2	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations

2Q Year 2	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations
3Q Year 2	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations
4Q Year 2	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations
1Q Year 3	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations
2Q Year 3	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations
3Q Year 3	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations
4Q Year 3	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations
1Q Year 4	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations
2Q Year 4	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations

3Q Year 4	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations
4Q Year 4	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations
1Q Year 5	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations
2Q Year 5	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations
3Q Year 5	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations
4Q Year 5	Implementation of trainings and TOM; review of TOM results and Implementation of quality improvements	Implementation of recruitment/retention plan; review of results; and implementation of quality improvement recommendations

Budget Report and Budget Narrative are attached.

Sustainability

As one of the largest behavioral health providers in the Commonwealth, generating more than 50 million dollars in claims annually, HFLW has an existing sustainable administrative infrastructure to guide us through every stage of complex project implementation. The DSRIP funding for the workforce development project proposed will provide capacity building funds as we add staff positions to our operating budget. The initial prep and year 1 budget periods will provide the agency with the time needed to budget for the additional staffing costs in years 2 through 5. We have built the proposed 5 year budget with the plans to absorb the salary costs over time gradually so that these positions are funded in the agency budget by the end of the contract term. HFLW will utilize existing meeting structures as tools for a) determining capital expenditures and b) determining and resourcing strategic initiatives. Membership at these

meetings consist of executive level leadership and key project leaders who report directly to the CEO and ultimately the Board of Directors. The DSRIP contract, and the associated strategic decisions and expenditures that will be developed further, evaluated and fully vetted by these groups. It is thru this process, as well as our newly developed monthly project meetings, that a sustainable financial plan will be established.

Section 6.5 Coordination with ACOs, MCOs, and Primary Care Providers

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A. Improving bidirectional communication between HFLW and pediatric practices

An integrated Electronic Health Record is crucial to high quality healthcare. The Home for Little Wanderers utilizes the Evolv system operated by NetSmart as the official documentation of health care. Evolv is a highly utilized and respected EHR that is capable of connecting to the Massachusetts Information Highway where the future of health care information sharing will ultimately be exchanged between providers, Managed Care Organizations and Accountable Care Organizations. In anticipation of this, The Home for Little Wanderers applied for and was chosen to participate in a MeHI, E-Quip pilot program designed to ensure that behavioral health providers like HFLW were prepared to be leaders in the information sharing future. In 2016, HFLW purchased the necessary software, connected to the Mass HIway and developed a bidirectional connection that enabled us to successfully share information with another provider soon after. We now have the capability to exchange health data with any pediatric practice that is connected to the Mass HIway or has an EHR that is a member of NetSmart's Health Information Services Provider (HISP).

In our efforts to further develop bidirectional communication with community Health Centers and Primary Care Clinicians, The Home for Little Wanderers will purchase Surface-Pro tablets that will allow our Care Coordinators to deliver care more effectively.

B. Improving referral management protocols for follow-up and informational sharing

Effective Care Coordination ensures that the exchange of patient information among providers, across settings, keeps the care team informed of the clients' health status, develops referral and information sharing protocols with relevant providers, stipulates expectations for access to the ICC service including plans for problem solving access issues, empowers family members to lead their care coordination teams through education and relevant health promotion strategies. Research indicates that "persons served by the public mental health system experience lower life expectancy, in part due to a lack of access to integrated physical and behavioral health care.[1]" Many of these patients, children and their families, present in a variety of community based settings including primary care offices, behavioral health centers and schools. Research has shown that the percentage of patients who initiate mental or behavioral health treatment after being referred by primary care physicians is low. Some of the reasons include ease of access, stigma, denial, and trust of a new service provider. Often the referral is made and the PCP will ask about it at the next medical appointment only to find out it never happened. The Home for Little Wanderers will utilize DSRIP funds to ensure that our workforce has the technology to track referrals, promote the ICC service, and share information across providers and have the

[1] Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors, Medical Directors Council; Editors: Parks, Svendsen, Singer, Foti, Technical Writer: B. Mauer. October 2006

training and coaching support that equops our workforce with these skills. The Home will be working with many PCPs and practices with varied staffing and electronic capabilities. Our relationship will begin by working with PCPs on their behavioral health screening tools and when behavioral health referrals are warranted. Once that is determined, the gold standard we envision is one in which PCPs utilize an electronic referral form that will include basic information (demographic, diagnosis, health insurance) and reason for referral. HFLW will pilot an electronic tool to provide PCP feedback on whether the patient scheduled and kept the appointment, and the results of the appointment (e.g. initial diagnosis /diagnostic impression, tests ordered, next steps, etc.). This referral management loop will help more patients get the behavioral health services they need and will identify those who fail to seek treatment.

C. Improving team-based treatment planning in collaboration with pediatric practices

Our Community Service agencies are highly experienced in wrapping treatment teams around the families that we serve. Unfortunately, time and demand often interfere with the participation of a primary care physician. To problem solve the lack of access of primary care to our treatment plans HFLW has embedded ICCs in health centers and been extremely diligent in communications to community health centers. While these efforts have certainly assisted us in connecting primary care physicians to the larger treatment team, technology has not been leveraged to its fullest extent because of cost. HFLW will continue to build on our relationships to engage primary care doctors in the treatment team planning. Our gold standard vision is to have a single, shared treatment plan with behavioral and medical health goals integrated with periodic team consultations. When that is not possible, at a minimum, we envision the mutual sharing (electronically) of assessments, treatment plans and treatment progress. In this way physicians will have direct access to their patients' behavioral treatment plans and behavioral health clinicians will have direct access to the medical treatment plans, which will enable mutual support and reinforcement of all treatment goals. A key element to treatment adherence is for the patient to take ownership and be driver of their own care. Each provider having a holistic view of all treatments will help support that ownership and ensure concurrent treatments are not contradictory.

D. Improving timely access to ICC services

HFLW acknowledges the critical importance of timely access to services for ICC enrolled members' engagement due to the unique challenges families face while raising children with Serious Emotional Disturbance. In fact, statistics demonstrate that engagement strategies such as "the warm hand off" or "same day access" significantly increase the chances that a patient will engage in services. In addition to strategies such as these which are already being implemented in our multiple partnerships with health centers, HFLW is proposing multiple technological strategies to increase timely access to ICC services. First, our workforce is in need of tablets with electronic signature software. This investment in the equipment of our front line care coordinators will help them be more mobile, research services with families, obtain electronic signatures for treatment plans and assessments and most importantly, allow our care coordinators to demonstrate to their families how they can leverage technology to more efficiently access their

care plan and communicate with their care plan providers electronically. Second, HFLW is HFLW is proposing to create a client portal where clients and caregivers can access their ICC and or PHI instantly and securely. We envision this portal to be a key scheduling strategy with our clients to prevent multiple phone calls and other forms of lagging communication that can limit timely access to care. In addition to the technology enhancements we are proposing two new staff support positions; one for training and one for recruitment to strengthen our workforce. The recruiter will play a crucial role in improving timely access to services by ensuring that our CSAs are fully staffed and vacancies are filled promptly with the right hires.

E. Improving connections to social services

The technology enhancements proposed in this response will be invaluable assets to our care coordinators as the landscape of our health care system moves away from a "fee for service" model to a "pay for performance" model. Our care coordinators need the tools that will make it simple to connect families to social services and simple for the family to maintain those connections in a way that the larger medical field has already made possible for their patients. Social Services play a key role in a family's wellbeing and/or path to recovery. It is our belief that with the help of our new trainer, the staff will feel better prepared to help ICC engaged members in maintaining and improving connections to social services.

CSA Budget Report

Wayside Youth and Family Support Network

Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites	2	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate	NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)	180	190	200	210	220	220	
Estimated Funds	$ 178,320.00	$ 133,000	$ 84,000	$ 63,000	$ 58,080	$ 26,400	**$ 542,800**
At- Risk Withhold Rate			5%	10%	15%	20%	
Withhold			$ 4,200	$ 6,300	$ 8,712	$ 5,280	**$ 24,492**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 178,320.00	$ 133,000	$ 79,800	$ 56,700	$ 49,368	$ 21,120	**$ 518,308.00**

Investment Projects	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Project 1 Name: Fostering Improved Care Integration via Implementation of Mobile Technology							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ 25,713	$ 13,328	$ 13,328	$ -	$ -	$ -	**$ 52,369**
Development Adaptation of EHR and/or Care Management System	$ 15,180	$ 12,000	$ 5,000	$ -	$ -	$ -	**$ 32,180**
Technology for Service Delivery	$ 58,000	$ 21,750	$ 30,000	$ 30,000	$ 30,000	$ 30,000	**$ 199,750**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 1 Total	$ 98,893	$ 47,078	$ 48,328	$ 30,000	$ 30,000	$ 30,000	**$ 284,299**
Project 2 Name: *Improving Access to Care: Building a Workforce of Effective Intensive Care Coordinators*							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ 35,040	$ 44,468	$ -	$ -	$ -	$ -	**$ 79,508**
Recruitment Expenses	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ -	**$ 25,000**
Training Expenses	$ 15,000	$ 10,000	$ 5,000	$ -	$ -	$ -	**$ 30,000**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ 19,359	$ 19,359	$ 19,359	$ -	**$ 58,077**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 2 Total	$ 55,040	$ 59,468	$ 29,359	$ 24,359	$ 24,359	$ -	**$ 192,585**
Total Project Costs	$ 153,933	$ 106,546	$ 77,687	$ 54,359	$ 54,359	$ 30,000	**$ 476,884**
Indirect Costs/ Administrative Overhead Rate 13%	$ 19,549	$ 13,531	$ 9,866	$ 6,904	$ 6,904	$ 3,810	**$ 60,564**
Investment Projects Total	$ 173,482	$ 120,077	$ 87,553	$ 61,263	$ 61,263	$ 33,810	**$ 537,448**

CSA Budget Report - Budget Narrative Prep Budget Period

CSA Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name: Fostering Improved Care Integra

DSRIP Project Goal(s):
1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-Eng*
2 *(3) Improving timely access to ICC services for children eligible to receive ICC and*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
IT Director	$ 100,000.00	0.2	5	$ 8,333
E.H.R. Manager	$75,000	0.2	5	$ 6,250
Vice President of Compliance	$ 160,000.00	0.1	5	$ 6,667
	$ -	0	5	$ -
				$ -
				$ -
	Total Salary	0.5		$ 21,250
	Fringe rate	21.0%	Total Fringe	$ 4,463
			Total IT Staffing including Fringe	$ 25,713

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.
The IT Director will purchase and configure laptops/tablets for CSA Staff use, ensure upkeep of the hardware and software and will manage all the security and staff training for the laptops/tablets.
The E.H.R. Manager will work directly with the E.H.R. vendor to ensure that the CSA-specific forms are developed properly and link with other necessary forms in system. E.H.R. Manager will also troubleshoot all individual E.H.R.-specific issues in the system and ensure the program is continuously running smoothly and efficiently.
The VP of Compliance will be responsible for the development of policies and procedures for mobile technology for Community-Based staff. There is currently no use of mobile technology in Community-Based work at Wayside.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Development of new CSA-specific forms in E.H.R. system	$ 15,180.00
Total Development and Adaptation of EHR and Care Management System	$ 15,180.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Wayside will be developing CSA-specific forms in the new E.H.R. that is selected. Cost is based upon the cost to develop and test and implement new CSA-specific forms in Wayside's current system. The cost quote was $220 hour for development and testing as follows:
Care Plan form=25 hrs
Family Indicator Form-- 12 hrs
Youth Indicator Form--12 hrs
SNCD form-12 hrs
Agenda Form--6 hrs
Attendance Sheet--2 hrs
Total of 69 hours form development=$15180.00.

Technology for Service Delivery

Description of Expense	Cost
laptops or tablets w/appropriate software and licenses	$ 48,000.00
Mobile Hotspots monthly services	$ 10,000.00
Total Technology for Service Delivery	$ 58,000.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Purchase of 40 laptop computers or tablets with all appropriate software and software licenses, virus protections, etc. Estimated at $1200 per laptop or per tablet. There are currently 40 FTE Care Coordinators, Family Partners, Sr. ICCs, and Sr. Family Partners between the 2 CSAs. This will allow for one laptop or tablet per staff FTE working in these programs.

Wifi "hotspots" @ $50/month for 40 laptops or tablets for 5 months. This will support all 40 FTE CSA staff currently employed in our 2 CSAs.

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Improving Access to Care: Building a V

DSRIP Project Goal(s):
1 *(3) Improving timely access to ICC services for children eligible to receive ICC an*
2 *(2) Strengthening fidelity to Wraparound processes, including the care planning*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

DSRIP Project Goal(s):
1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Workforce Development - Prep Budget Period

Project 1 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name: Building and Retaining an Effective Wo

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Talent Acquisition Manager	$ 80,000.00	0.2	5	$ 6,667
CSA Program Director Lowell	$ 95,000.00	0.2	5	$ 7,917
CSA Program Director Framingham	$ 65,000.00	0.2	5	$ 5,417
VP of Community Services	$ 150,000.00	0.1	5	$ 6,250
Clinical Compliance Coordinator	$ 65,000.00	0.1	5	$ 2,708
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0.8		$ 28,958
	Fringe rate	21.0%	Total Fringe	$ 6,081
			Total Workforce Development Staffing including Fringe	$ 35,040

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.
Talent Aquisition Manager and CSA Program Directors will develop formal relationship including development and execution of formal internship program with UMass Lowell and Framingham State University. Talent Aquisition Manager will devote an average of 8 hours/week to this project for 5 months. CSA PDs will devote an average of 4 hours/week to this project for 5 months.
VP of Community Services to develop and execute MOU with universities and oversee project, ensuring milestones are met. Estimated 4 hours per week of time over a 5 month period.
Clinical Compliance Coordinator and CSA PDs to develop a comprehensive training for all CSA staff in "The Golden Thread of Medical Necessity." This training will be in 3 different formats specifically for different level staff: MA level, BA level, and Family Partners. The Clinical Compliance Coordinator will devote 4 hours/week to this project and the PDs will devote 4 hours each/week.

Recruitment Expenses

Description of Expense	Cost
Advertising of positions on new sites	$ 5,000.00
Total Recruitment Expenses	$ 5,000.00

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Advertising costs for "typical" job sites with positions highlighted so that they come up first in job searches. Cost is estimated for total of 2 different major sites for a 5 month period of time. We are quoted $2500/month under our current contract to highlight 5 unique positions on the Indeed website.(breaks down to about $500 per unique position each month) We would like to be able to highlight the ICC positions for each of Lowell and Framingham ($1000 total per month) for 4 months each ($4000) and additionally highlight Family Partner positions for each program site for one month ($1000). Although we may seek new sites on whcih to advertise, we are using real costs for this budget as we have been quoted them to date.

Training Expenses

Description of Expense	Cost
Motivational Interviewing Advanced Training	$ 5,000.00
10 Sr. Level CSA Staff Tier 1 Certification	$ 10,000.00
Total Training Expenses	$ 15,000.00

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Staff at both CSAs will receive advanced training in Motivational Interviewing so that they will be able to continue to train new staff in the model as they come on board. MI is a key method Wayside uses towards improving engagement of clients. To do this we will have an expert MI trainer come on-site for two separate full days at the cost of $2500 per full day training. It is a flat cost and we anticipate that a total of 10-12 CSA staff will participate.

All supervisory and management level staff at both CSAs will become Tier I Certified in Wraparound. Estimated to cost $1000/staff X 10 staff.

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 1 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
	Total Salary	0		$ -
	Fringe rate		Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate: 13.00%

Provide a brief description of how the Indirect Cost/Administrative Overhead rate was determined:

This is Wayside's Federally Approved Indirect Cost Rate for FY 2018

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS March 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
1	Technological Developments for CSA Staff	E.H.R. forms specific to CSA will be developed and successfully implemented	01/01/18	12/31/18	**Technology**	Development Adaptation of EHR and/or Care Management System	Adequate forms will be developed and reviewed initially with E.H.R. vendor	completion of mock-up of forms and delivery to vendor			Forms will be completed and built in E.H.R. system for testing	Forms will be available for testing in system		
		All CSA Staff (both ICCs and Family Partners) will be trained and will use tablets/laptops in the field for all Care Coordination Activities	01/01/18	12/31/22	**Technology**	Technology for Service Delivery	Laptops/tablets purchased and configured	completion of purchase and configuration of laptops/tablets			All CSA staff will have their own laptop/tablet and been trained in its use.	All CSA staff will be using laptops/tablet for care management activity in the community.		
		Policies and Procedures for use of Mobile Technology at Wayside will be completed	01/01/18	05/31/18	**Technology**	Technology for Service Delivery	Workgroup established to develop this policy and procedure	At least one meeting will have been held			Written documentation of policy and procedures for use of mobile technology will be completed.	Full writing and vetting of policy completed and entered into agency manual.		
					Technology	Other Technology Expenses								
2	Building and retaining an effective workforce	Develop and formalize relationship with UMass Lowell and Framingham State for Internship program	01/01/18	12/31/18	**Workforce Development**	Workforce Development staffing including Fringe	Meet with key folks at Umass Lowell and Framingham State	Meetings held and plan developed			MOU for partnership completed and signed	Signed MOU		
		Increase number of staff working in the CSAs	01/01/18	12/31/18	**Workforce Development**	Recruitment Expenses	Research and identify new advertising methods	Post positions in at least 2 new recruitment forums			Multiple new candidates will apply for positions within CSA	Increased staff from baseline		
		Build training module for Medical Necessity Documentation and implement for all new staff	01/01/18	12/31/18	**Workforce Development**	Training Expenses	Develop workgroup to address this item	workgroup will meet at least 3 times			Pilot training module will be developed and testing begun for different levels of staff	At least 2 MA-level, 2 BA-level, and 2 Family Partners will have tested the newly developed training module		
		Sr. level staff at both CSAs will become certified in Motivational Interviewing	01/01/18	12/31/19	**Workforce Development**	Training Expenses	Identify appropriate training session for staff to attend and schedule/register	at least 2 CSA staff will be identified/registered for an upcoming certification training			Sr. CSA staff will be certified in Motivational Interviewing	At least 1 additional Sr. staff at CSA will have completed the certification training.		
		Supervisory/management staff at both CSAs will become Tier 1 certified in Wraparound	01/01/18	12/31/18	**Workforce Development**	Training Expenses	Identify appropriate session for staff to attend.	At least 2 additional CSA staff will be registered for Tier 1 certification course			Completion of Tier 1 Certification for management staff at CSAs	At least 2 of the CSA management staff will have attended Tier 1 certification course		
					Operational Infrastructure	Operation Staffing including Fringe								
					Operational Infrastructure	Other Operational Expenses								
					Operational Infrastructure									
					Operational Infrastructure									

SECTION 6: PROGRAMMATIC RESPONSE

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Section 6.2 Executive Summary:

Wayside Youth & Family Support Network is pleased to serve as the Community Service Agency for the Framingham and Lowell Areas. Wayside has served in this capacity for Framingham since the inception of the CBHI in 2009. Wayside subsequently became the CSA for the Lowell Area on 12/31/2012 when the previous CSA in Lowell opted to discontinue its contract.

Overall, Wayside's Framingham and Lowell CSA development plans share a focus on expanding and improving timely access to Intensive Care Coordination (ICC) and Family Support and Training (FS&T) services, as well as continuous improvement in reaching high fidelity Wraparound, most specifically in the areas of strengthening community connections, natural supports, and team based collaboration. Both sites have common and unique strengths as well as needs that are being addressed on their respective development plans.

The strengths of Wayside's Lowell CSA include a steady enrollment of an average of 115 youth, a vibrant System of Care with a consistent membership of 25-30, and a growing team of staff that provide significant cultural and linguistic diversity. The strengths of Wayside's Framingham CSA include a core team of staff that have been part of the CSA since its inception in 2009, and Family Partners that have various expertise in adoption, substance abuse, transition aged youth, and Grandparents as primary caregivers.

Both the Lowell and Framingham CSAs share common strengths of strong community connections and significant knowledge of community resources to support the families enrolled. In addition, both CSAs have strong partnerships with local health centers and primary care practices. The Lowell CSA has received several referrals from Lowell Community Health Center and Lowell Pediatrics and has strong partnerships with their multidisciplinary teams. In this same vein, the Framingham CSA has experience working with multiple medically complex youth and has had successful collaborations with Children's Hospital and the UMass Hospital system.

As another area of strength, Wayside's overall commitment to recruitment, staff retention and staff training have begun to yield successful outcomes. Since Wayside hired a fulltime staff recruiter in 2015 approximately 15 new Intensive Care Coordinators and 7 new Family Partners have been hired. Between both CSAs combined, approximately 55 % of staff have been in their positions for over 2 years. This past year all Wayside agency staff have been trained on using Motivational Interviewing and several staff have participated in an Intensive Learning Community focused upon the ARC model. Additionally, several staff have participated in the Family Partner CBHI course through Urban College; others have completed Wraparound Tier One Certification, and various Wraparound Refreshers. Wayside also provides monthly free clinical trainings on topics such as trauma, substance abuse,

diversity, and working with specialty populations such as immigration, divorce, adoption and parental mental health.

A significant area of need for both the Framingham and Lowell CSAs is to improve timely access to ICC services. Each site's development plan has a priority goal to eliminate wait times for ICC services by increasing capacity by hiring more staff. This goal also matches a key Wayside goal on the agency strategic plan. The action steps identified to reach this goal includes increased recruiting efforts through various external platforms, increasing compensation and benefits, cross-training existing staff and developing an internal career ladder to promote upward mobility into Care Coordination roles.

In addition to these existing strategies, Wayside has recently partnered with Middlesex Community College to develop a Children's Behavioral Health Certificate program that will establish a work force pipeline for Family Partners and Therapeutic Mentors. As will be outlined in one of our proposed projects in this proposal, Wayside plans to develop similar partnerships with Framingham State University and UMass Lowell to establish a workforce pipeline for Intensive Care Coordinators through internships and service learning projects.

Another area of development that both CSAs have been focusing on is increasing high fidelity Wraparound in the areas of strengthening sustainable community connections, natural supports and team based coordination. The action steps identified to reach these goals consist of monthly focus groups within the CSA team to brainstorm new strategies and create achievable action steps; increased frequency of initial Wraparound training and regular Wraparound Refreshers on specific phases and principles.

To this end, this past year both CSAs have been active participates in their respective regional Wraparound coaching teams. Both regions have been focusing on joint initial Wraparound trainings as well as monthly joint Wraparound refreshers. In the Northeast Region 7 Lowell CSA staff have received Tier One Wraparound Certification and in the Central Region, an initial Wraparound training is scheduled to begin this coming year. All CSA staff have participated in Wraparound Refreshers within their own CSA, as well as refresher trainings hosted by other CSAs in the region.

Lastly, an area of focus for both CSAs to develop is in strengthening coordination with pediatric primary care. Although, there has been some recent success as previously mentioned through an increase in referrals and specific collaborations, more work is needed. Action steps towards achieving this goal include developing better internal systems and efficiencies, and improving technology focused upon increasing communication and ongoing planning with pediatricians. Our second proposed project outlined below details further specifics towards reaching this goal.

Section 6.3 Populations Served and Community Engagement:

Wayside's Framingham Area CSA covers 23 cities and towns, including Framingham and the surrounding area. The Lowell Area CSA covers 13 cities and towns, including Lowell and the surrounding area. All of the youth served by the CSA meet the eligibility criteria stated in the ICC and FS&T service specifications.

As noted earlier, Wayside Youth & Family Support Network has served as the Community Service Agency for the Framingham Area since June 30, 2009 and for the Lowell Area since December 31, 2012. Both of our CSAs are well-connected within these Service Areas; one with a much more longstanding historical connection and the other more recently connected.

Wayside as an organization has been embedded in the Framingham Community for almost 40 years. Founded in 1977 in Framingham, Wayside has been serving children and families with behavioral health conditions, child welfare involvement, and high-risk environments in a variety of capacities since that time. Wayside's mission is to build strength, hope and resiliency in children, families, and communities through a youth and family development model that sees youth as assets and partners and families as the most valuable resource in the lives of their children. Through its full continuum of residential and community services--funded primarily by DCF, DMH, and Insurance--Wayside serves a culturally, economically and linguistically diverse population of youth and their families. Wayside is well-connected to the MetroWest Community both as a result of its history in the MetroWest Area as well as the community-based manner in which all of our programs operate; we are successful because of the connections we hold and the value we place upon these connections. Throughout this particular region we operate a full continuum of care for children, young adults, and families.

In the Lowell Area, Wayside's presence is much newer but is equally robust. When we took over the Lowell CSA on December 31, 2012, Wayside "inherited" 8 families to our brand new CSA. As of this writing, Wayside serves over 200 families in the Lowell Area at any one given time via the combination of our CSA, along with our IHT and TM teams. As noted earlier, our System of Care Committee is robust and active. Our presence in the community is palpable with many more families seeking our services than we are currently able to serve.

Through the System of Care Committees both CSAs have developed and fostered relationships with various state agencies, such as DMH, DDS, DCF, and on occasion DYS. Other partnerships include the Middlesex Juvenile Court, area CBHI providers, public school systems, including area charter schools, the Family Resource Center, faith based organizations, and various community providers such as the YMCA, Boys & Girls Club, Girls Inc., Community Team Work.

The mission and guiding principles of the System of Care are grounded in the Wraparound philosophy. The monthly meetings are a forum to network, collaborate and foster relationships with community and system partners. This monthly collaboration has led to an increase in staff

knowledge of services and community resources. The monthly System of Care meetings have also promoted strong collaboration amongst service providers; which in turn has resulted in individualized needs of ICC-enrolled youth being met consistently. Concurrently, our relationships with this full network of child and family serving agencies, school systems across the communities, providers of behavioral health services, DCF, DMH, DYS, the courts, and social service agencies are instrumental in identifying youth and families who can benefit from our CSA services. Our continued nurturance of these relationships is critical to our CSAs.

The System of Care Network and guiding principles will also be used to strengthen collaboration with primary care pediatric practices. The CSA Program Directors will increase System of Care memberships to include key staff from area practices. The Lowell System of Care already includes membership of staff from Lowell Community Health Center and Greater Lowell Pediatrics. There will be significant outreach efforts by the Lowell and Framingham Program Director to increase membership by more pediatric practices for both the Lowell and Framingham areas. Wayside will leverage its very robust set of existing relationships in these communities as we seek to improve the quality of our ICC services.

In addition to building upon the System of Care Committee membership, there will be significant targeted training on collaboration with primary care. As outlined in Section 6.4, training for Care Coordinators will contain modules that focus on increasing knowledge and collaboration skills. Topics will include screening/assessment and treatment of co-occurring medical conditions, overview of common medical conditions in children/adolescents, and collaboration with primary care practices.

Our proposed projects—one focused upon workforce development, the other focused upon efficiencies achieved by improved technology—are directly connected to our partnerships. By being able to more quickly, effectively and efficiently serve families referred to our CSAs we are better able to meet the needs identified by our partnership organizations. Wayside already has a protocol for outreach and active engagement of families who might be interested in or referred to our CSA. This protocol will be further enhanced by improved access and efficiency achieved by our proposed projects.

Section 6.4 Proposed Project(s) and Investment Plan:

A) Project Description:

As noted earlier, Wayside Youth & Family Support Network has two CSAs—Framingham and Lowell. In our response to this RFR we seek to implement two different projects that will be implemented across both of our CSAs. Below we will describe each project separately and will refer to them going forward by their titles.

Project #1: Fostering Improved Care Integration via Implementation of Mobile Technology (hereafter referred to as "Project #1")

Project #1 seeks primarily to improve the integration of care for ICC-engaged members via the use of mobile technology. Concurrently, we believe that the use of technology will also improve efficiency in care which will, in turn, help improve access to care and coordination.

Mobile technology, such as laptops or tablets, will assist CSA staff in increase communication and participation with all Care Plan Team members, specifically pediatric primary care. With the use of mobile devices CSA staff will be able to communicate with primary care providers electronically via email or skype, while in the presence of the family in their home. Assessment and treatment plan information can be written in collaboration with the family and readily shared with team members. Additionally, attendance of pediatricians and nursing staff at Care Plan Meetings can be enhanced through the use of skype.

Mobile communication will also serve as an aid to provide 'real time' coaching with the family on effective treatment plan collaboration with team members, specifically their primary care providers. In addition to increasing effective collaboration with team members, CSA staff will use mobile technology while in the field with families to access additional community resources, complete on-line referrals, and as a vehicle for psychoeducation through web-based research.

The most significant portion of funds will be needed during the first year of the project. During this time, we will purchase either laptops or tablets for CSA staff to use while in the field working directly with clients. Along with the hardware needed, each staff person will also require a mobile hotspot to ensure internet access while in the community at all times. This latter cost will continue for the entirety of the funding cycle. However, it is concurrently hoped that the cost for this ongoing use of mobile technology will eventually be able to be absorbed into the other ongoing administrative costs expended by the program.

Internal resources necessary to implement this project include an up-front amount of time spent by Wayside's IT Director to both purchase and configure the correct hardware for this purpose. Subsequently, this resource will be needed only to maintain the integrity of the hardware, troubleshoot problems that might occur, and ensure appropriate upgrades are done on a consistent basis.

Funds to be allocated for this project will be allocated across the two Wayside CSAs based upon the number of Intensive Care Coordinators and Family Partners working at any given time out of each CSA. Access to the exact same resource will be provided to each ICC, regardless of the CSA site out of which they work.

Effectiveness of this proposed project will be measured by improved Wraparound fidelity scores in the area of Team-based Coordination and Effective Teamwork on the TOM. It will also be measured by improved productivity and efficiency of staff who will be able to document their work "in the moment" which will significantly improve their overall efficiency in coordinating care.

Specific targets and measurements proposed are as follows:

Target #1	There will be stronger communication and collaboration with all Care Plan Team members.
Evidence of Progress:	WIFI scores in Team-Based Coordination will improve to 75% (current score average is 65% for Lowell and Framingham combined.) TOM score in Effective Teamwork will improve to 93% (current score average for Lowell and Framingham combined is 86%)
Target Date:	BP2 (December 31, 2019)
Measurement Tool(s):	WIFI TOM
Responsible Party:	Program Director
Target#2	Improved efficiency and productivity of all CSA staff, resulting in improved access to care for clients.
Evidence of Progress:	Elimination of waitlist for CSA services at both CSAs
Target Date:	BP1 (December 31, 2018)
Measurement Tool:	Waitlist data
Responsible Party:	Program Directors/Intake Coordinators

Project #2: Improving Access to Care: Building a Workforce of Effective Intensive Care Coordinators (hereafter referred to as "Project #2"):

Project #2 seeks to improve timely access to care for children eligible to receive ICC services and their families by developing a robust and sustainable recruitment and training program for new Intensive Care Coordinators. It also seeks to strengthen fidelity to the overall Wraparound process via advanced training for supervisory staff in Wraparound and for a number of CSA staff in Motivational Interviewing.

To this end, Project #2 will include the development of a partnership with two key institutes of higher education—UMass Lowell and Framingham State College. These partnerships will ensure that there is a steady stream of potential applicants for these positions by virtue of an internship program whereby Wayside will offer ICC internships towards college credit. In addition, this project will also include the "beefing up" of some of our current recruiting efforts as it relates to Intensive Care Coordinators.

Additionally, a team of Senior Staff at both of Wayside's CSAs will work in concert with the agency Clinical Compliance Coordinator to develop the curriculum for a specific training module on the "Golden Thread of Documentation." This curriculum will be developed in 3 different ways—one geared towards MA level staff, one geared towards BA level ICCs, and one geared towards Family Partners. This module will be developed, vetted, and loaded into the agency's on-line training system for use on an ongoing basis with new staff who are hired.

Finally, we seek to increase the level of skill and competence of specific CSA staff in both Motivational Interviewing and in Wraparound. Towards this end, we seek to provide advanced level training to staff in these models as a way to ensure ongoing sustainability of the training needs of the programs going forward. We will ensure that 10-12 staff in both CSAs received advanced training in Motivational Interviewing. Additionally, up to 10 Sr. level CSA staff will become Tier 1 Certified in Wraparound. We feel strongly that both of these advanced levels of training will enhance the services offered by our CSAs and also ensure sustainability of training for the programs moving forward.

Much of the cost for this project will come in the preparation period and in year 1 as we seek to develop the partnerships with the colleges, build our curriculum, and develop processes for the ongoing internships. We will then subsequently "roll out" the new training program, make adjustments as needed and, when appropriate adjustments have been made, the program itself will be sustainable with minor adjustments as needed in future years. We anticipate that funds received will support the project through two full years at which point the project will be self-sustaining.

Specific targets and measurements proposed are as follows:

Target #1:	Wayside will increase the number of new ICC hires in a timely manner and, as a result, access to services will improve.
Evidence of Progress:	Size of CSA caseload at each site will increase. Current CSA caseload in Framingham is 65 and in Lowell is 110 (December 1, 2017). Caseload in Lowell will increase to an average of 125 and
in	Framingham to an average of 90.
Target Date:	BP2 (December 31, 2019)
Measurement Tool(s):	Caseload Averages
Responsible Party:	Program Director /Intake Managers

Target #2:	CSA staff at all levels will improve their fidelity to Wraparound
and	overall client engagement via advanced training in Wraparound
and	Motivational Interviewing.
Evidence of Progress:	Total average WIFI scores for Wayside will improve to 75% (current average for both CSAs together is 63%) Total average TOM scores for Wayside will improve to 83% (current Wayside overall average for both CSAs together is 78%)
Target Date:	BP2 (December 31, 2019)
Measurement Tool(s):	TOM WIFI
Responsible Party:	Program Directors

B)Project Team Description:

Roles/Responsibilities of Staff Involved in Project

Staff Name	Staff Title	Role in Project
Beth Chin, LICSW	Program Director—Lowell CSA	Coordination/oversight of projects; facilitation of development of training curriculum, development of training curriculum, facilitation and development of relationship with local colleges
Kim Ward, LICSW	Program Director—Framingham CSA	Development of training curriculum
Heather Polidi, LICSW	Sr. ICC—Framingham CSA	Development of training curriculum; implementation of training curriculum, internship supervisor
Beth Kelner, LICSW	Sr. ICC—Lowell CSA	Development of training curriculum; implementation of training curriculum, internship supervisor
Amanda McClintock, LMHC	Sr. ICC-Lowell CSA	Development of training curriculum; implementation of training curriculum, internship supervisor
Patrick Keaton	IT Director	Purchase and setup of new mobile hardware

The project team will be led by Beth Chin who will coordinate all aspects of the projects and, in doing so, will ensure all efforts are coordinated among staff. Upon award of the contract, she will develop a work plan with clear timeframes for completion of tasks associated with the project and will report weekly on progress to her supervisor (Vice President of Community Services).
Each staff person assigned to this project is uniquely qualified to serve in this capacity by virtue of their current agency roles. In particular, each Senior. staff person in the respective CSAs is qualified for their Wayside jobs via their educational credentials, licensure, and their training in all of the program specifications for the services delivered by the CSA. Wayside's IT Director is also uniquely qualified for his role via his role and responsibilities for Wayside as an organization.

Attached, please find the job descriptions for Wayside's CSA Program Directors and Senior Intensive Care Coordinators. Attached also please find the Wayside Organizational Chart.

C) Implementation Plan and Timeline:

Monthly Implementation Timeline
Preparation Budget Period: January 1, 2018-May 31, 2018 (5 mos)

Project	Domain	Task	Jan	Feb	Mar	April	May
Project #1 (Mobile Technology)							
	Hardware	Identify appropriate hardware to purchase	x	x			
		Purchase laptops/tablets			x		
		Prepare and disperse mobile technology to staff				x	x
	Quality/Risk Management	Develop processes for info sharing, secure encryption, and how to use mobile technology				x	
	Training	Train staff in use of mobile technology					x
Project #2 (Workforce Development)							
	Planning	Meeting of all team members to develop work plan	x				
		Establishment of responsibilities for writing module	x				
	Curriculum Development	Research and write curriculum		x	x		
		Review curriculum				x	
		Finalize curriculum					x
	Relationship with Colleges	Meeting with UMass Lowell and Framingham State University to formally establish partnership		x			
		Development of MOU			x	x	
		Finalize MOU					x

Monthly Implementation Plan
Budget Period 1: June 1, 2018-December 31, 2018 (7 mos)

Project	Domain	Task	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Project #1 (Mobile Tech)	Training /Implementation	Train staff on best practices in use of mobile technology for better care integration	x	x					
		Staff begin using mobile technology in primary care settings and other community locations			x				
Project #2 (Workforce Development)	Curriculum Implementation	Upload new curriculum to Relias	x						
		Test use of new curriculum module on existing staff		x					
		Make appropriate adjustments to curriculum			x				
		Train first new staff on new curriculum				x	x		
		Train all new staff on new curriculum						x	x
	Relationships with colleges/internship development	Develop clear guidelines for undergraduate internships	x	x	x				
		Develop and publish internship description				x	x		
		Interview potential interns						x	x

Quarterly Implementation Plan
Budget Period 2: January 1, 2019-Dec. 31, 2019

Project	Domain	Task	Q1	Q2	Q3	Q4
Project #1 (Mobile Technology)	Implementation	Continue to use mobile technology	X	X	X	X
Project #2 (Workforce Development)	Training	Continue to train new staff on curriculum	X	X	X	X
		Continue to make adjustments/update curriculum	X	X	X	X
	Internship Development	Interview and onboard first class of undergraduate interns	X			
	Internship Development	Make adjustments to undergraduate internships based on experience			X	X
	Quality/Reporting	Produce reports			X	X

D.Budget Report and Budget Narrative:

See Attachments B and Attachment C

E) Sustainability:

Wayside Youth & Family Support Network will endeavor to sustain the investments made in these projects both during and beyond the contract term
.
First, by meeting (and exceeding!) the requirements for this contract, we will maintain the funding afforded to us.

Then, by definition of the purpose of these projects—"Capacity-Building"—we will improve our overall capacity to better serve more clients, more efficiently. By meeting the goals of these capacity building projects, we anticipate that we will increase the number of clients served in a timely manner out of our CSAs, while concurrently maximizing productivity of staff by hiring more staff, quickening their training process, and maximizing efficiencies in their time. As a result, we will be able to not only increase the numbers of clients served, but also maximize revenues to be gleaned from the increased clientele.

Section 6.5 Coordination with ACOs, MCOs, and Primary Care Providers:

Consistent communication and collaboration will be a key strategy to ensuring ICC-enrolled youth meet their health and wellness goals indicated on their individualized care plan. Communication between the CSA and pediatric practices will be multi-modal and rely on both staff collaboration skills and technology efficiencies.

Wayside has already established communication protocols that begin at the referral process, which include contacting the pediatric practice upon referral once consent has been obtained. Contact to the practice consist of phone calls, email communication and requesting and sharing assessment information. Increased technology as outlined in Section 6.4 will provide efficient means of sharing information via secure email and through mobile capacity.

Secure email will allow for an increase in sharing of protected health information through a safe and protected platform. The use of mobile devices will increase means to communicate information with all team members, including pediatric practices, through a collaborative process with family members present.

The Care Planning Team (CPT) will continue to be the primary means for treatment planning for all ICC-enrolled youth. Families will be highly encouraged to include members from their multi-disciplinary primary care team to all CPT meetings. Mobile devices will be used to allow capacity for members to skype into meetings when not able to attend in person.

Referral management for both CSAs will continue to be led by a team of Master level clinicians to assess for needs and medical necessity for ICC services. Increasing referrals from ACOs, MCOs, and Primary Care Providers will be a significant area of focus. There will be significant outreach efforts by the CSA Program Director and Referral Team to educate all primary care practices in their respected areas. ACOs, MCOs, and Primary Care Practices will receive weekly communication by the Referral Team on the status of openings and to confirm member enrollment.
In addition, the System of Care Committee will serve as the monthly forum to increase collaboration amongst the ACOs, MCOs, Primary Care and community service programs. This ongoing forum of monthly face-to-face collaboration will be a key factor in increasing the likelihood for achieving successful outcomes for youth.

6.4 Proposed Project and Investment Plan #1

A. Project Description

1. Name of specific project: Workforce Recruitment Improves Timely Access

2. Specific goal: The goal of this project is to Improve Timely Access to Intensive Care Coordinator (ICC) Services for children eligible to receive ICC and their families through a strategic campaign to increase the number of Masters-level ICCs by a minimum of six additional ICCs over a three-year period within the CSA programs sited in Southbridge and Milford, MA. A workforce increase of six will ultimately improve the timely access to ICC services for approximately 185 additional children and their families eligible to receive such services. To this end, YOU, Inc. plans to engage in a cross-departmental process to develop a strategic recruitment and talent branding campaign to increase its CSA workforce, and to add .5 FTE Clinical Talent Acquisition Specialist dedicated to the task of launching the campaign in year one, and then stepping down in number of hours to maintain the activity over subsequent years. This campaign will formally bring together the expertise of the Human Resources and Marketing departments with the CSA Operational staff. It will be constructed and implemented in year one, with these efforts continuing and sustained beyond as part of our infrastructure.

3. Scope of the project: The duration of this Workforce Recruitment Improves Timely Access project is from November 2017 through December 2020. To achieve the goal above the project will begin with a kickoff meeting, which will include CSA managers, members of the Human Resources and Development and Marketing departments, and key ICC supervisors to analyze and evaluate current practices and plan for the full implementation of this project. The activities to be performed over the project to achieve the above goal will include, at minimum:

- Utilizing a licensed MA/MSW level clinician as an embedded .5 FTE Clinical Talent Acquisition Specialist within our CBHI services area. This position will function as a liaison between the CSA and Human Resources department to improve talent recruitment, vetting practices, and hiring efficiency. Utilizing an experienced clinician who has provided CBHI services will strengthen our ability to more clearly articulate and represent the responsibilities and demands of the ICC position in talent branding and in-person recruitment opportunities. This Clinical Talent Acquisition Specialist will also vet qualified Master Level ICC candidates by listening for competency. Improved vetting practices will result in securing qualified candidates, while streamlined communication to Human Resources will result in hiring candidates more quickly.
- Utilizing the same licensed MA/MSW level clinician will also strengthen talent acquisition efforts by dedicating a portion of their .5 FTE time to talent branding on social media, representing the CSA at career fairs, developing relationships with local colleges/universities career departments, working to retain graduate-level interns, etc.

- Updating our website and applicant tracking system to streamline the application process and to highlight agency benefits, including loan forgiveness, a licensing scholarship, annual and specialized training opportunities, as well as highlighting successful outcomes from working with families and children.
- Centralizing and implementing electronic recruitment processes within the HR department including reference checks, screening and coordination of the on-boarding plan.
- Sending a postcard (both hard copy and digital) to current licensed and unlicensed Master level candidates describing sign-on bonuses and the value of working at YOU, Inc. (Lists can be obtained from the MA Board of Professional Licensure).
- Designing a new brochure that specifically targets the benefits of a career at YOU, Inc.
- Providing a series of well-advertised Open Houses throughout Central MA where the Clinical Talent Acquisition Specialist and current ICCs will describe their job and answer questions, with on-the-spot interviews conducted to facilitate a rapid hiring process.
- Utilizing social media and new online recruitment channels to both advertise current ICC openings and to engage potential passive candidates

4. Proposed Deliverables: The following deliverables will result from the Workforce Recruitment Improves Timely Access Project:

1) The CSA will increase the number of qualified Master-level ICC candidates by six additional ICCS, a 40% increase over current staffing, within 3 years.
2) The CSA will demonstrate efficient hiring practices by making an offer to qualified candidates within 10 business days of completed application and interview process.
3) The CSA will decrease vacancy time for ICC positions by an average of 5 days.
4) The CSA will increase the total number of ICCs by a minimum of 6 additional ICCs within 3 years:
    a. The CSA will increase the workforce by a minimum of 2 new ICCs in year one.
    b. The CSA will increase the workforce by a minimum of 2 new ICCs in year two.
    c. The CSA will increase the workforce by a minimum of 2 ICCs in year three.
5) Once #4 above is achieved, an additional 55 youth/families will be served by the CSA, resulting in an expected average monthly enrollment of 185 families.

5. Specific use of DSRIP Funding: DSRIP funding for this project includes the .5 FTE Clinical Talent Acquisition Specialist (CTAS) position, the printing of new talent branding/marketing materials, and recruitment travel expenses. These investments directly support a specific recruitment effort to increase the number of ICCs; such an increase supports both workforce development and access to timely services but reducing the waitlist. Other costs in this project, such as design of the marketing materials, CSA management time overseeing the CTAS, etc., is not part of the DSRIP funding and is an in-kind contribution by YOU, Inc.

6. Existing Internal Resources: The agency proposes to utilize a number of existing internal resources to support this Workforce Recruitment Improves Timely Access Project. Firstly, the

agency refreshed its marketing identity, from logo to tagline to messaging, this past year. This project can benefit from that process and build off of it. Similarly, the agency is currently creating a new, mobile-responsive website that should enhance recruitment efforts and aid the Clinical Talent Acquisition Specialist. Secondly, existing managers will provide consultation, support and/or supervision to members of the project team. The agency's new Marketing Manager will also provide consultation and design work for the new talent branding/marketing efforts. Project staff will be located in existing sites in Worcester, Milford and Southbridge. Finally, project staff will have access to existing technology, including computers, printers, scanners, etc.

7. Allocation of Funds: The funds for this project specified in the Budget Report and Narrative (Attachments B and C) will be allocated as follows: to the Human Resources department for the .5 CTAS position, with the remainder of the funds allocated to the CSA for marketing and printing, and recruitment travel across all CSA sites. The YOU, Inc. CSA program services the South Central area, which encompasses a large part of Southern Worcester County. This area covers from Franklin on the eastern side of the catchment area to Sturbridge on the western side. The largest towns within the area are Southbridge, Webster, Northbridge, Milford and Franklin.

8. Internal Evaluation, Measurement, and Performance Management Strategies: In order to measure the efficiency and effectiveness of our recruitment and marketing plan, the Project Team will utilize a tracking system to track data relative to volume of candidates, and timely hiring of qualified candidates to ICC position. Response rates for digital talent branding and marketing efforts for this project will be evaluated by the Marketing Manager and discussed with the CTAS and CSA management team each quarter.

B. Project Team Description

1. See attached Organizational Chart.

For 2. List of Current Staff, 3. Proposed Staff, and 4. Roles and Responsibilities of Staff for this project, please see Table 1 below:

The Workforce Recruitment Improves Timely Access Project Team will be comprised of the Director of Human Resources, the Marketing & Communications Manager, the Director of Community Based Services (CBS), the Director of the Community Services Agency (CSA), and the Clinical Talent Acquisition Specialist. Only the latter, noted in bold below, is funded by DSRIP funding, the rest of the staff time below will be an in-kind contribution by the agency.

Name	Title	Qualifications	Project Role/Responsibility
Joellen Andrews	Director of Human Resources	5 years as an HR Director, 17 in the field, MBA	Provide oversight of the project and co-supervision of the Clinical Talent Acquisition Specialist (CTAS)

			Facilitate team meetings to review project recruitment goals and progress
TBD (currently being hired)	Marketing & Communications Manager	3+ years in marketing design and print and digital communications	Provide design and consultation on the talent branding/marketing efforts of the CTAS
Kim Jeznach	Talent Acquisition Specialist	4+ years as a Nonprofit Recruiter and Talent Acquisition Specialist	Assist the CTAS in implementing the social media, in-person, and digital plans to recruit new ICCs
Judi Rock	Director of Community Based Services		Provide supervision and support of the Director of Community Service Agency Monitor hiring efforts with the Director of CSA
Joanna Cyr	Director of Community Service Agency		Provide co-supervision and support for the CTAS Monitor recruitment and marketing efforts
TBD, Proposed staff of the project	**.5 Clinical Talent Acquisition Specialist**	**Proposed:** Experience working in a CSA required; experience in marketing or recruiting desired.	Act as a liaison between CSA and the Human Resources and Marketing departments Implement the talent branding/marketing plan for ICCs Represent the CSA at career fairs, open houses, on-campus at colleges/universities Screen and vet all ICC candidates for qualifications, proper credentials, clinical skill and experience Track recruitment outcomes

5. Management of the Project: The project team will be comprised of staff in key leadership positions within the agency (see table above), but it is the Director of CSA, Joanna Cyr, who is responsible for the recruitment and retention of CSA staff and who will directly coordinate and manage this Workforce Recruitment Improves Timely Access project. Specifically, the Program Director will coordinate bi-weekly planning meetings with the project team in order to monitor progress toward project timeframes and goals. The Program Director will monitor tracking data for trends, will ensure that the Clinical Talent Acquisition Specialist represents the CSA at local career fairs, and that established practices for ensuring efficient hiring are implemented and being maintained.

C. Implementation Plan and Timeline (Table 2, All Projects):

Budget Period	**Project 1: Recruitment**	**Project 2: Community Outreach**	**Project 3: Coaching**	**Project 4: Technology**
Preparation Budget Nov. and Dec. '17	Identify staffing of the Clinical Talent Acquisition Specialist (CTAS) position; Hold Kickoff meeting of CSA managers, HR and Marketing departments, and key ICC supervisors; Design marketing materials; Train CTAS	Identify: Staffing of the Community Outreach Specialist (COS); Work plan for outreach to ACOs and PCPs; Present obstacles in coordinating healthcare and develop a plan to address them; Train COS	~~Initial VROON VDB Wraparound Coaching Training & Certification on-site is held.~~	Purchase and distribute new netbooks to all ICC staff; Purchase Data Analysis System; MIS and CSA leadership meet to determine 5 key metrics for Data Analysis System implementation.
Preparation Budget Jan. through March '18	CTAS schedules and attends initial college & career fairs visits, posts first marketing items online; Update website & HR processes; Mail postcards; Schedule/ advertise Open Houses.	Educate ICCs, Senior CCs, Family Partners, and Central Referral on role of COS; Create marketing materials; Develop Evaluation Plan and data entry methods; COS makes initial	On-Site "Booster" training by NWIC is held ~~See above~~	Implement Data Analysis System with 5 data metrics to be used in Years 1-5.

		outreach visits COS completes UMASS Integrated Care Management certification		
Year 1, Q2	CTAS reduces hours from 20 to 6 per week; CTAS conducts recruitment visits and marketing tasks; HR tracks data on deliverables; CTAS vets candidates- ongoing thru Q4	COS reduces hours from 20 to 8 per week; COS conducts outreach visits and tracks data—ongoing thru Q4	~~Two days of follow-up VROON training will be conducted~~ Leadership team attends NWIC Academy in Washington D.C. Quarterly NWIC support for leadership team through Virtual Coaching Platform and access to NWIC training modules and resources	See above
Year 1, Q3	See above	Monitor and adjust work plan as needed	See above	See above
Year 1, Q4	Evaluate initial data tracked, marketing outcomes, etc. and adjust Year 2 work plan as needed	Evaluate initial data tracked and adjust Year 2 work plan as needed	See above	Evaluate initial data metrics and tracking and report out to team.
Year 2, Q1	CTAS reduces to 4 hours per week; CTAS conducts recruitment efforts and marketing tasks—ongoing thru Q4	COS reduces to 4 hours per week; COS conducts outreach visits and tracks data—ongoing thru Q4	~~Minimum of 6 supervisors receive coaching certification by end of Year 2, Q2~~ Leadership team attends NWIC Academy in Washington D.C.	See above

			Quarterly NWIC support for leadership team through Virtual Coaching Platform and access to NWIC training modules and resources	
Year 2, Q2	See above	See above	Quarterly NWIC support for leadership team through Virtual Coaching Platform and access to NWIC training modules and resources~~See above~~	See above
Year 2, Q3	See above	See above	Quarterly NWIC support for leadership team through Virtual Coaching Platform and access to NWIC training modules and resources~~See above~~	See above
Year 2, Q4	Evaluate tracked data and adjust Year 3 work plan as needed.	Evaluate tracked data and adjust Year 3 work plan as needed	~~Two days of follow-up VROON training will be conducted; All current ICC staff complete TIER II certification by Year 2, Q4~~ Quarterly NWIC support for leadership team through Virtual Coaching Platform and access to NWIC training modules	Evaluate data metrics and report out to CSA team; Add at least 2 new data metrics to be used in Years 3-5.

			and resources	
Year 3, Q1	CTAS reduces to 2 hours per week as function begins to be embedded in agency staffing—ongoing thru Year 3, Q4.	COS reduces to 2 hours per week as function begins to be embedded in agency staffing; COS conducts outreach visits and tracks data—ongoing thru Year 5, Q4	See above	See above
Year 3, Q2	See above	See above	See above	See above
Year 3, Q3	Evaluate tracked data for deliverables and to inform permanent position (see below)	See above	See above	Evaluate data metrics and report out to CSA team.
Year 3, Q4	DSRIP-funded CTAS position concludes; position added to HR	See above	~~All new ICC staff will receive certification by Year 3, Q4~~	Add at least 2 new data metrics to be used in Years 4 and 5.
Year 4, Q1	n/a	See above	n/a	See above
Year 4, Q2	n/a	See above	n/a	See above
Year 4, Q3	n/a	See above	n/a	See above
Year 4, Q4	n/a	See above	n/a	See above
Year 5, Q1	n/a	See above	n/a	See above
Year 5, Q2	n/a	See above	n/a	See above
Year 5, Q3	n/a	See above	n/a	See above
Year 5, Q4	n/a	Finalize embedding of COS function into agency staffing	n/a	Add at least 2 new data metrics to be used going forward.

D. Budget Report and Budget Narrative (see attachments B and C)

E. Sustainability

The main way this project will be sustained over time will be the ongoing increase in revenue generated by the additional CSA workers hired into the program. Like with all services, a percentage of the revenue will go to management and general costs that support the agency

administration. This revenue will allow us to maintain the identified part time .50 position hired through DSRIP dollars, enhancing the Human Resources department, thus increasing the ongoing ability to attract and maintain qualified staff who serve more ICC-eligible children and families. This position would become a permanent full time position in the Human Resources department. This goal is reasonable, given the likelihood that agency revenue will continue to increase as more billable hours are generated.

6.4 Proposed Project and Investment Plan #2

A. Project Description

1. Name of specific project: Community Outreach

2. Specific goal: The goal of this Community Outreach Project is to improve the integration of ACOs and Primary Care Providers for ICC-engaged members and their families. YOU, Inc. will accomplish this with the addition of a Community Outreach Specialist who will further strengthen our existing partnerships with ACOs and PCPs and who will network with additional ACOs and PCPs within the Milford and Greater Southbridge communities. This effort will include a focused and intensive marketing campaign designed to educate ACOs and PCPs and their staff to the benefits of the wraparound CSA model of services working in conjunction with them on the same goal: improving healthcare services and, in turn, the health of our shared clientele. The Community Outreach Specialist will complete the UMass Integrated Care Management certificate program and through a train the trainer model, will provide the CSA staff with training and support in this model. The Community Outreach Specialist role will be integrated into the CSA Program as a 0.5 FTE position, allowing the required tasks to be accomplished over our wide geographic area.

3. Scope of the project: The Community Outreach Project lasts from November 2017 through December 2020. The initial .5 FTE Community Outreach Specialist (COS) position lasts from November 2017 through March 2018; thereafter the position steps down from .2 FTE in Year 2 to .05 FTE to maintain activity in Year 5 before that function becomes embedded in the CSA service. The COS's focus will be to engage with PCPs and ACOs within the communities with three major outcomes:

- Networking and relationship building,
- Comprehensive education concerning CSA and its wraparound services, and
- Improving the coordination and integration of services across these systems of care for ICC-engaged members.

We will accomplish these goals through:

- A strategic and comprehensive public relations (PR) plan within the entire catchment area. Key elements will include the targeted use of social media, a newly designed and updated set of marketing materials including a new brochure, postcards, and business cards, as well as access to a newly designed website page highlighting the CSA program.
- The Community Outreach Specialist (COS) will maintain regular communication with providers, and will assess which mode of communication is more suited to each provider, e.g., some pediatricians or psychiatrists prefer texting or messaging, while others prefer a direct phone call. However, what is essential to this plan is that regular face-to-face meetings will also take place. This relationship building will lead to problem-solving, thus improving the integration of services.
- The COS will also have access to agency giveaways such as water bottles, pens, notepads, keychains, posters for pediatric offices, etc. to keep YOU, Inc. and its CSA front-of-mind for providers.
- Critical to this plan's success will be the knowledge base of ICC and Family Partner services, the community, and the ability to share success stories. Therefore, the COS will be someone with direct knowledge of the value of intensive wraparound services, the target population and the communities in which it is delivered. The COS will also complete the UMass Integrated Care Management certificate program.

4. **Proposed Deliverables:**

1. A new CSA brochure as well as marketing postcards will be created and printed, with a minimum of 500 combined creative pieces put into circulation over the course of a year.
2. In visits with PCPs the COS will problem-solve barriers to care when appropriate and discuss increasing integration of care. Attendance by PCPs at our System of Care meetings will be tracked and the number attending at least twice yearly will increase by a minimum of 10%.
3. With the assistance of our MIS Department we will develop a data tracking system to measure the following outcomes:

- Number of new PCPs and ACOs receiving regular face to face contact
- Overall number of regular meetings with ACOs and PCPs

5. Specific use of DSRIP Funding: DSRIP funds will be used to fund the cost of the COS position, UMass Integrated Care Management certificate program cost, outreach materials (print and online), as well as outreach travel expenses. This investment will allow YOU, Inc. to jumpstart significantly the improvement of the integration of ACOs and Primary Care Providers for ICC-engaged members and their families for the agency's CSA.

6. Existing Internal Resources: Internal resources that will support this plan will include staff supervision, office space, office supplies, existing technology and training.

7. Allocation of Funds: The funds for this project specified in the Budget Report and Narrative (Attachments B and C) will be allocated to the CSA for the COS position, marketing and

printing, UMass Integrated Care Management certification training, and outreach travel across all CSA sites. The YOU, Inc. CSA program services the South Central area, which encompasses a large part of Southern Worcester County. This area covers from Franklin on the eastern side of the catchment area to Sturbridge on the western side. The largest towns within the area are Southbridge, Webster, Northbridge, Milford and Franklin.

8. Internal Evaluation, Measurement, and Performance Management Strategies: In order to measure the efficiency and effectiveness of our Community Outreach Project, the Project Team will utilize a tracking system to track data relative to the number of new PCPs and ACOs receiving regular face to face contact, the overall number of regular meetings with ACOs and PCPs, and attendance by PCPs at our System of Care meetings. Responses for outreach marketing efforts for this project will be evaluated by the Marketing Manager and discussed with the COS and CSA management team each quarter.

B. Project Team Description

1. Organizational Chart: Please see attached.

2. **List of Current Staff**: Judi Rock, LICSW Component Director, Joanna Cyr, LICSW Program Director II, Marketing Manager (currently being hired).

3. Proposed Staff: One 0.5 FTE (20 hours per week) Community Outreach Specialist, stepping down to a .05 FTE through December 31, 2022.

4. Roles and Responsibilities of Staff: The Component Director will oversee this project in partnership with the Program Director. The Program Director will directly supervise the COS and be responsible for the evaluation of the project. The Marketing Manager will design the creative pieces for the project and consult with the Community Outreach Specialist on their implementation. The Community Outreach Specialist will be directly responsible for implementing all goals identified in the Project Narrative.

5. Management of the Project: This project will be overseen by Judi Rock, LICSW, Component Director. She will directly supervise Joanna Cyr, LICSW, CSA Program Director. Together they will identify staffing and implement this project. As they meet weekly, all aspects of the start-up and implementation will be discussed regularly. In addition, Ms. Rock and Ms. Cyr will schedule longer planning meetings at least quarterly. Senior ICCs, ICCs and Family Partners will be informed of this service and trained as to how to use the COS within their roles.

C. Implementation Plan and Timeline: Please see Table 2 on page 5.

D. Budget Report and Budget Narrative (see attachments B and C)

E. Sustainability: It is projected that the Community Outreach Specialist project will be completed over a one year period. This project will give us a huge jump start on engaging PCPs and ACOs regularly to increase care integration and healthcare outcomes. After the project's completion, the CSA leadership will embed aspects of it into the regular budget and practice of the program.

6.4 Proposed Project and Investment Plan #3

A. Project Description

1. Name of specific project: ~~Coaching Certification of Wraparound Staff~~

NWIC Wraparound Coaching "Boosters" and CSA Leadership Support & Training

2. Specific goal: The goal of this project is to strengthen fidelity to Wraparound processes including care planning, care management and care coordination processes for ICC engaged members and their families. This proposed project will directly impact the skill sets of the ICC staff in providing a high-quality wraparound process specifically in the areas reflected in our fidelity scores and provide direct support to the CSA leadership team for sustainability.~~.~~

3. Scope of the project: The duration of time that funding will be utilized will be during the budget preparation period and during the first two budget years ~~for this Coaching Certification of Wraparound Staff project~~. YOU, Inc. proposes funding for partnering with the National Wraparound Implementation Center (NWIC) to provide "booster" trainings to the CSA staff that will be individualized and tailored for the YOU Inc. CSA program based on the areas where Wraparound fidelity scores have been low and where our staff struggle in regards to providing high fidelity wraparound. This will include trainings for staff on including natural and community supports in the wraparound process, using creative brainstorming and options when developing a wraparound plan with a family and ensuring that care plans are created using outcome measurements so families and teams can see progress. We have made contact with Kim Estep, Director & Systems & Content Expert Coach at NWIC to provide this intensive on-site "booster" training and ongoing leadership support. Kim and her team of coaches at NWIC will be able to review the YOU Inc. CSA WAFAS data to design their trainings to tailor around the program's specific needs. NWIC will be able to provide on-site "booster" training to the entire program staff that is tailored to our individual needs as well as provide support to our supervisory leadership team both on site and through a "Virtual Coaching Platform". Through this intensive training and coaching support, we will build sustainability in providing high fidelity wraparound to our ICC engaged members and their families. ~~hiring an outside trainer to provide coach certification for the Sr. ICC staff and Sr. Family Partner staff, in order to have sufficient certified coaches to provide ongoing coaching and training in the wraparound model for all ICC staff. We have made contact with Jim Rast of~~

~~Vroon VDB, a nationally recognized trainer of wraparound and a trainer who has been utilized by MassHealth to provide coaching for the CSA's. Jim has submitted a proposal to provide coaching at a site in Worcester for our staff. We can also open this up to other CSA's that want to send senior staff to receive the training.~~

~~High Fidelity Wraparound training is an important first step in creating sustainable High Fidelity Wraparound services.~~ In addition to the training modules provided by the state, our CSA will improve overall fidelity to the wraparound model by focusing on these areas of need for our staff and a model of ongoing support for our leadership team to sustain this fidelity. Research has shown that training without ongoing coaching may not result in fidelity. Coaching is a long term investment in sustainability and change. Through the support of NWIC, our leadership team will receive ongoing coaching and support on a quarterly basis as well as have access to an extensive library of training modules and related resources through their virtual training center. This will be provided through the end of Budget Year 2. ~~Coach training presents the skills necessary for coaches to make a lasting impact on the quality of wraparound provided at the agency. The Vroon VDB certification process is designed with the goal of having each site certify multiple certified Wraparound coaches toward developing a strong learning culture and providing high fidelity, sustainable wraparound.~~

~~Coaching and Certification of ICC staff is a major factor in workforce development. By providing ongoing Tier I and Tier II certification for ICC staff, they strengthen their skills in facilitating the wraparound process and improve their fidelity to the wraparound model. This training enhances staff's sense of professional skills and fosters a greater commitment to their role as Wraparound facilitators.~~ On-site, intensive training from the highly skilled, energetic coaching team at NWIC will provide our staff the necessary "boosters" they need to improve their practice in Wraparound. With improved skills and refreshing ideas, staff will gain confidence in the work they do and the Wraparound model as a whole. We believe this will increase retention of staff and allow staff a greater sense of professional development.

~~We are proposing a 'train the trainer' model which will certify our senior supervisors as coaches and enable them in turn to train ICC staff and provide certification for them. This will allow us to utilize the funds initially to fund the training of the supervisors and all costs will be incurred in the initial years of funding. After that period, trained supervisors will be able to ensure that coaching can be sustained in order to certify ICC staff.~~ We are focusing a large portion of this training to be with our CSA leadership team of supervisors and Senior ICC and Senior Family Partner staff. We feel as though providing support and training to this team will strengthen our internal training for the CSA staff therefore leading to strengthened fidelity to the Wraparound process. We would propose to send a minimum of 2 supervisors from our CSA leadership team to the NWIC Academy in September of 2018 and also in 2019 to further strengthen and sustain their skills in providing effective supervision and training to our CSA staff.

4. Proposed Deliverables: (A) ~~-~~ On-site "Booster" training will be provided for the CSA staff by June 2018. ~~A minimum of 6 supervisors will receive coaching certification by no later than June 2019~~. (B)CSA Leadership staff will receive on-site coaching and support as well as virtual coaching through December 2019 on a quarterly basis ~~All current ICC staff will complete Tier II certification as a wraparound facilitator by December 2019~~. (C) ~~New ICC staff will receive certification by December 2020.~~A minimum of 2 CSA Leadership staff will attend the NWIC Academy in September, 2018 and then again in 2019.

5. Specific use of DSRIP Funding: DSRIP funds will be used to fund the cost of the ~~trainer's time~~NWIC coaching team, as well as ~~his~~ their travel expenses. The funds will also provide the CSA access to NWIC's extensive library of training modules and related resources through the virtual training center and fund the cost of the quarterly virual coaching sessions with the leadership team through the end of Budget Year 2. The DSRIP funds will also be used to send a minimum of 2 senior or supervisory staff from the CSA to attend the NWIC Academy held in September 2018 and 2019. The funds will be used to pay for their registration to the Academy and their travel costs. ~~The YOU, Inc. CSA program services the South Central area, which encompasses a large part of Southern Worcester County. This area covers from Franklin on the eastern side of the catchment area to Sturbridge on the western side. The largest towns within the area are Southbridge, Webster, Northbridge, Milford and Franklin. Through this investment of funds, staff will be certified in wraparound and the goal of strengthening the wraparound processes will be attained. Additional costs will be utilized for ongoing coaching of the participants to complete the certification process.~~

6. Existing Internal Resources: YOU, Inc. plans to utilize its senior managers, as well as experienced ~~ICC~~ staff in this CSA project to continue to support and train the CSA staff in high fidelity Wraparound and sustain the skills developed through the support of the NWIC coaching team.~~, to become certified as trainers in order to sustain the goal of certifying all ICC staff. We will also utilize agency training space and training tracking.~~

7. Allocation of Funds: Funds will be allocated for the training of all CSA staff at both the ~~the training of supervisors from both~~ Milford and Southbridge sites as well as the ongoing coaching support for the leadership team of supervisors.~~.~~

8. Internal Evaluation, Measurement, and Performance Management Strategies: The CSA program will partner with the agency QM and Training Department to track the ~~progress of supervisors working toward their certification~~training of staff via the agency's electronic learning platform. The CSA program will also work with ~~the trainer/consultant~~NWIC for tools that can strengthen our capacity to efficiently collect and effectively use data to monitor our fidelity to the Wraparound process. ~~be utilized to track the certification process and tasks that need to be completed and timelines established.~~

B. Project Team Description

1. See attached organizational chart

2. List of Current Staff: The Project team would consist of Joanna Cyr, LICSW, Program Director of the CSA, Judi Rock, LICSW, Component Director of Community Based Services, as well as Sr. ICC Hilary Fernandes, LMHC and Sr. ICC Margaret Langley, LMHC. The project team will also include Sr. Family Partner Dolores Toribio and Sr. Family Partner Cheryl Marino-Page. This team will work with NWIC to develop the "Booster" trainings for the CSA staff and also participate in the on-site and virtual coaching for the leadership team. ~~the outside consultant to complete the coach certification process.~~ This team will participate in the ~~initial training,~~onsite training as well as ongoing virtual coaching through at least the first 2 year budget periods. ~~several days of follow-up training to complete all requirements for certification.~~

3. Proposed Staff: The bidder plans to hire a consultant/trainer for this project. YOU, Inc. plans to contract with the National Wraparound Implementation Center (NWIC) to provide on-site coaching to the CSA staff as well as ongoing support to the leadership team through virtual coaching. ~~has already received a proposal from Jim Rast of Vroon VDB, a nationally recognized coach of wraparound staff. VVDB has been training and working with coaches across North America for over 20 years and certifying over 400 coaches in our system. During that time, VVDB has learned new strategies for training and new ways for maximizing training transfer. Based on this, VVDB has developed a new coaching textbook and curriculum that compiles all of our learning from our experience coaching and supervising on our programs to training and coaching across North America.~~

4. Roles and Responsibilities of Staff: The Senior Managers, Judi Rock and Joanna Cyr, will oversee the project and provide the coordination with the consultant to ensure efforts are coordinated and not duplicated.

5. Management of the Project: The Program Director of the CSA, Joanna Cyr, will be responsible for managing the project. She will develop goals and objectives to organize the implementation of this project and she will report out project accomplishments/progress towards goals semi-annually to Component Director Judi Rock.

C. Implementation Plan and Timeline: Please see Table 2 on page 5.

D. Budget Report and Budget Narrative (see attachments B and C)

E. Sustainability: This project is highly sustainable as it focuses the coaching support on the supervisory team who then directly supervise the CSA staff and who create the sustainable trainings that will continue beyond the funding periods of this proposal. ~~creates a group of trainers who will provide ongoing coaching and training for ICC staff without incurring additional cost beyond the initial periods of funding.~~

6.4 Proposed Project and Investment Plan #4

A. Project Description

1. Name of specific project: Leverage and expand technology to capture, analyze and share relevant data.

2. Specific goal: The goal of this project is to utilize our existing Electronic Health Record system (and its connection to the Mass HIway) to strengthen the use of data, and improve the integration of ACOs and Primary Care Providers. By providing our Intensive Care Coordinators with updated technology, we anticipate they will be more efficient in documenting service delivery and coordinating care for our families. In addition, the implementation of a data analytics system will allow our staff to better track referrals, service delivery, and residential treatment admissions, in addition to many other data metrics. While the data analytics system will implemented in the Preparation Period, the creation of additional data metrics will continue through Year Three.

3. Scope of the project: The duration of this technology project is from November 2017 through December 2022. The focus will be to improve the ability to document and access data with two major outcomes:

- Deployment of new end-user technology (netbooks) to document service delivery and care coordination more efficiently.
- Improve the efficiency and quality of our services through the implementation of a data analytics system to better track key metrics.

We will accomplish these outcomes through:

- Creating new and utilizing existing data sets within CareLogic (our existing EHR) to improve data collection amongst our CSA staff. Those data sets will be used to create dashboard to drive workflow changes. We believe that data alone doesn't improve performance, but that adapting and changing workflows leads to client outcomes.
- Connecting our EHR to the Virtual Gateway for a more efficient entry of the CANS.
- Coordinating care more efficiently by sharing clinical documentation with other community partners through the use of the Mass HIway.

4. Proposed Deliverables: (A) It is expected that all Intensive Care Coordinators will receive netbooks by December 2017. (B) Implementation of the Data Analytics System will be complete with 5 data metrics by the end of the Preparation Period. (C) An additional two (2) data metrics will be created and utilized in 3 subsequent years.

5. Specific use of DSRIP Funding: DSRIP funds will be used to fund the cost of netbooks and signature pads for clinical staff as well as the purchase and implementation of a data analytics system. The netbooks and signature pads are expected to cost $15,000. The data analytics system is expected to cost $40,000. This includes both implementation costs and monthly licensing fees. Through this investment of funds, staff will be better able to document service delivery, track significant data metrics, and gain efficiency in use of time.

6. Existing Internal Resources: YOU, Inc. plans to utilize its MIS Staff, Quality Management staff and CSA program leadership to develop dashboards and data metrics.

7. Allocation of Funds: Funds will be allocated for purchase of netbooks for CSA clinical staff as well as for the purchase and implementation of a data analytics system. YOU, Inc. will cover the costs of the data analytics system by more than half in Year 2 (.6 in-kind) and increasing every year until .9 in-kind in Year 5. The YOU, Inc. CSA program services the South Central area, which encompasses a large part of Southern Worcester County. This area covers from Franklin on the eastern side of the catchment area to Sturbridge on the western side. The largest towns within the area are Southbridge, Webster, Northbridge, Milford and Franklin

8. Internal Evaluation, Measurement, and Performance Management Strategies: The Chief Information Officer, Database Administrator, Director of Quality Management, and EHR Specialist will work with CSA program staff to create tools to collect and analyze measurable data, and to evaluate progress towards deliverables.

B. Project Team Description

1. See attached organizational chart

2. List of Current Staff: The project team would consist of Jonathan Miller, Chief Information Officer, Kathleen Fleming, Database Administrator, Chris Darling, EHR Specialist, Joanna Cyr, LICSW, Program Director of the CSA, Judi Rock, LICSW, Component Director of Community Based Services, and Jillian Alfeo, LMHC, Director of Quality Management. The team will work with the data analytics vendor to implement the system. This team will participate in training on the system and will work with program staff to understand and utilize the data to achieve desired outcomes.

3. Proposed Staff: none.

4. Roles and Responsibilities of Staff: Jonathan Miller, Chief Information Officer, will oversee the project to ensure efforts are coordinated and not duplicated.

5. Management of the Project: Jonathan Miller, Chief Information Officer, will be responsible for managing the project. He will develop goals and objectives to organize the implementation of this project.

C. Implementation Plan and Timeline: Please see Table 2 on page five.

D. Budget Report and Budget Narrative (see attachments B and C)

E. Sustainability: Through the use of data analytics, we anticipate being able to deliver services in a more efficient manner while also providing better care coordination. This increased efficiency will allow us to service more families. While still early, we anticipate that we could reduce costs while increasing the number of services delivered, allowing us to easily sustain this effort.

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CSA Budget Report

Youth Opportunities Upheld (YOU), Inc.

Investment Funding	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Revenues
Number of CSA sites	1	N/A	N/A	N/A	N/A	N/A	
PMPM Infrastructure Rate	NA	$ 100.00	$ 35.00	$ 25.00	$ 22.00	$ 10.00	
Estimated ICC-Engaged Members (Monthly Average)	130	130	130	130	130	130	
Estimated Funds	$ 102,120.00	$ 91,000	$ 54,600	$ 39,000	$ 34,320	$ 15,600	**$ 336,640**
At- Risk Withhold Rate			5%	10%	15%	20%	
Withhold			$ 2,730	$ 3,900	$ 5,148	$ 3,120	**$ 14,898**
TOTAL MAXIMUM FUNDS AVAILABLE	$ 102,120.00	$ 91,000	$ 51,870	$ 35,100	$ 29,172	$ 12,480	**$ 321,742.00**

Investment Projects	Prep Budget Period	Budget Year 1	Budget Year 2	Budget Year 3	Budget Year 4	Budget Year 5	Total Expenses
Project 1 Name: *Workforce Recruitment Improves Timely Access*							
DSRIP Goal(s) Addressed: Goal 1:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Goal 2:	*Optional*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ 12,990	$ 30,700	$ 12,300	$ 6,150	$ 6,150	$ -	**$ 68,290**
Recruitment Expenses		$ -		$ -	$ -	$ -	**$ -**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure							
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 1 Total	$ 12,990	$ 30,700	$ 12,300	$ 6,150	$ 6,150	$ -	**$ 68,290**
Project 2 Name: *Community Outreach*							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 3:	*(3) Improving timely access to ICC services for children eligible to receive ICC and their families*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure							
Operation Staffing including Fringe	$ 12,990	$ 30,700	$ 12,300	$ 12,300	$ 6,150	$ 3,075	**$ 77,515**
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	**$ -**
Project 2 Total	$ 12,990	$ 30,700	$ 12,300	$ 12,300	$ 6,150	$ 3,075	**$ 77,515**
Project 3 Name: *NWIC Wraparound Coaching "Boosters" and CSA Leadership Support & Training*							
DSRIP Goal(s) Addressed: Goal 1:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						
Goal 2:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 3:	*Optional*						
Technology							
IT Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Development Adaptation of EHR and/or Care Management System	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Technology for Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Technology Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Workforce Development							
Workforce Development staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Recruitment Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Training Expenses	$ 9,450	$ 4,000	$ 5,200	$ -	$ -	$ -	**$ 18,650**
Retention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Operational Infrastructure							
Operation Staffing including Fringe	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Other Operational Expenses	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Project 3 Total	$ 9,450	$ 4,000	$ 5,200	$ -	$ -	$ -	**$ 18,650**
Project 4 Name: *Leverage and expand technology to capture, analyze and share relevant data*							
DSRIP Goal(s) Addressed: Goal 1:	*(1) Fostering strong integration with ACOs and primary care providers for ICC-Engaged Members*						
Goal 2:	*(2) Strengthening fidelity to Wraparound processes, including the care planning, care management, and care coordination processes for ICC-Engaged Members and their families*						

	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ 39,340	$ 14,600	$ 15,800	$ 12,410	$ 12,410	$ 7,895	$ 102,455
Technology for Service Delivery		$ 15,000	$ -	$ -	$ -	$ 940	$ -	$ 15,940
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 4 Total		$ 54,340	$ 14,600	$ 15,800	$ 12,410	$ 13,350	$ 7,895	$ 118,395

Project 5 Name: *[Project title here]*

DSRIP Goal(s) Addressed:	Goal 1:	*Required*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 5 Total		$ -	$ -	$ -	$ -	$ -	$ -	$ -

Project 6 Name: *[Project title here]*

DSRIP Goal(s) Addressed:	Goal 1:	*Required*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 6 Total		$ -	$ -	$ -	$ -	$ -	$ -	$ -

Project 7 Name: *[Project title here]*

DSRIP Goal(s) Addressed:	Goal 1:	*Required*						
	Goal 2:	*Optional*						
	Goal 3:	*Optional*						
Technology								
IT Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Development Adaptation of EHR and/or Care Management System		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Technology for Service Delivery		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Technology Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Development								
Workforce Development staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Recruitment Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Retention Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operational Infrastructure								
Operation Staffing including Fringe		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operational Expenses		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Project 7 Total		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Project Costs		$ 89,770	$ 280,000	$ 45,600	$ 30,860	$ 25,650	$ 10,970	$ 282,850
Indirect Costs/ Administrative Overhead Rate		$ 12,350	$ 11,000	$ 6,270	$ 4,240	$ 3,522	$ 1,510	$ 38,892
Investment Projects Total		$ 102,120	$ 91,000	$ 51,870	$ 35,100	$ 29,172	$ 12,480	$ 321,742

CSA Budget Report - Budget Narrative Prep Budget Period

CSA Budget Report - Technology - Prep Budget Period

Only complete this Infrastructure Budget Narrative using amounts anticipated for PBP.
Lines may be added to the Infrastructure Budget Narrative tables as necessary

Project 1 Name:Workforce Recruitment Improve
DSRIP Project Goal(s): 1 *(3) Improving timely access to ICC services for children eligible to receive ICC and*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:Community Outreach
DSRIP Project Goal(s): 1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E.*
2 *(2) Strengthening fidelity to Wraparound processes, including the care planning,*
3 *(3) Improving timely access to ICC services for children eligible to receive ICC an*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:NWC Wraparound Coache
DSRIP Project Goal(s): 1 *(2) Strengthening fidelity to Wraparound processes, including the care planning,*
2 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E.*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:Leverage and expand tech
DSRIP Project Goal(s): 1 *(1) Fostering strong integration with ACOs and primary care providers for ICC-E.*
2 *(2) Strengthening fidelity to Wraparound processes, including the care planning,*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Data Analytics Software	$ 39,340.00
Total Development and Adaptation of EHR and Care Management System	$ 39,340.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Data Analytics software includes the purchase and monthly fee costs. This software will allow service providers the ability to measure and analize service provision, goal achievement, fidelity of service, and measurable gains. Additionally, it will allow service providers the oportunity to share data with collateral parntners and to make service adjustments as needed.

Technology for Service Delivery

Description of Expense	Cost
Hardware - 30 Netbooks	$ 15,000.00
Total Technology for Service Delivery	$ 15,000.00

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

These netbooks, which will include auxilary equipment (e.g. signature pads) will allow practitioners the ability to conduct concurrent documentation in the field, allowing them to be more efficient and to conduct wraparound services.

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:
DSRIP Project Goal(s): 1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:
DSRIP Project Goal(s): 1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:
DSRIP Project Goal(s): 1 *Required*
2 *Optional*
3 *Optional*

IT Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total IT Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Development/Adaptation of EHR and/or Care Management System

Description of Expense	Cost
Total Development and Adaptation of EHR and Care Management System	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Technology for Service Delivery

Description of Expense	Cost
Total Technology for Service Delivery	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Other Technology Expenses

Description of Expense	Cost
Total Other Technology Expenses	$ -

Provide a description of each IT line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Workforce Development - Prep Budget Period

Project 1 Name:Workforce Recruitment Improve

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Talent Acquisition Specialist	$ 42,240.00	0.5	6	$ 10,560
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0.5		$ 10,560
Fringe rate	23.0%		Total Fringe	$ 2,429
			Total Workforce Development Staffing including Fringe	$ 12,990

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

The Talent Acquisition Specialist is responsible for the recruitment of professional-level staff with either experience or potential for experience in wrap-around services, in order to best build relationships with collateral health professionals and increase client access to services.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:Community Outreach

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary				$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:NWC Wraparound Coache

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary				$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Booster training	$ 8,450.00
Integrated Care Management	$ 800.00
Total Training Expenses	$ 9,450.00

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

This includes a 2-Day on-site intensive "booster" training provided by the National Wraparound Implementation Center (NWIC). This training will assist staff in building sustainable child capacity, to provide model-adherent, high-quality wraparound, thereby increasing positive outcomes for children, youth and families.

Integrated care management certificate training, provided by UMASS, will allow for a higher level of training sophistication so that care improvements and client care quality can improve while providing wraparound services.

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:Leverage and expand tech

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary				$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary				$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary				$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Workforce Development Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary				$ -
Fringe rate			Total Fringe	$ -
			Total Workforce Development Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, and how each will assist in executing activities related to the project.

Recruitment Expenses

Description of Expense	Cost
Total Recruitment Expenses	$ -

Provide a description of each recruitment expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Training Expenses

Description of Expense	Cost
Total Training Expenses	$ -

Provide a description of each training expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Retention Expenses

Description of Expense	Cost
Total Retention Expenses	$ -

Provide a description of each retention expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Operational Infrastructure - Prep Budget Period

Project 1 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 2 Name:Community Outreach

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
Community Outreach and				$ -
Development Liaison	$ 42,240.00	0.5	6	$ 10,560.00
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary		0.5		$ 10,560.00
Fringe rate	23.0%		Total Fringe	$ 2,428.80
			Total Program Staffing including Fringe	$ 12,990.00

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

The Community Outreach and Development Liaison is responsible for developing partnerships with health providers throughout the service area. The Liaison will develop 1:1 relationships as well as service groups that work in a collaborative manner in order to assure that clients receive the best health care possible.

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 3 Name:NWC Wraparound Coache

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 4 Name:Leverage and expand tech

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 5 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 6 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

Project 7 Name:

Operational Staffing including Fringe

Position	Annual Salary	FTEs	# Months	Total
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
Total Salary	0			$ -
Fringe rate			Total Fringe	$ -
			Total Program Staffing including Fringe	$ -

For each position listed above, provide a brief statement of the position's responsibilities, how each will assist in accomplishing the goals of the project:

Other Operational Expenses

Description of Expense	Cost
Total Other Operational Expenses	$ -

Provide a description of each operational expense line item included in the table above, how each will assist in accomplishing the goals of the project and how the costs were determined:

CSA Budget Report - Indirect Cost/Administrative Overhead- Prep Budget Period

Indirect Cost/Administrative Overhead Rate: 10.74%

Provide a brief description of how the Indirect Cost/Administrative Overhead rate was determined:

Represents the salaries, benefits and payroll taxes for the following administrative employees (executive, accounting, human resources, information technology, quality assurance, marketing) and the costs related to those employees (ie. Office supplies, occupancy, training, telephone, equipment rental and maintenance, etc).

CSA Milestones Report

CSA must have at least one implmentation goal with at least one milestone for each project number. An implmentation goal may have more than one milestone.

Investment Project Number	**Investment Project Name**	**Implementation Goal**	**Goal Start Date**	**Anticipated Goal End Date**	**Investment Category**	**Investment line Item within Category**	**PBP Update - Due to EOHHS March 31, 2018**				**Report on PBP - Due to EOHHS August 31, 2018**			
Ties back to project number or budget report	*Should be same name as on Budget report*	*Describe specific goal (e.g. implement care management software)*	*Dates only between 7/1/17 and 12/31/2022*		*Select from drop down menu*	*Select from drop down menu*	**Anticipated Milestone Target by 3/31/18**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**	**Anticipated Milestone Target by End of PBP (5/31/18)**	**Evidence of Success**	**Has Milestone been met? (Y/N)**	**If NO, please explain:**
4	Leverage and expand technology to capture, analyze and share relevant data	Implement Data Analysis System	01/01/18	12/31/21	**Technology**	Development Adaptation of EHR and/or Care Management System	Complete research of Data Analysis Systems	5 Key metrics for Data Analysis System identified by MIS and CSA leadership			Purchase Data Analysis System	Data analysis system is implemented		
4	Leverage and expand technology to capture, analyze and share relevant data	Strengthen the use of data and improve integration with ACOS and Primary Care Providers	01/01/18	12/31/21	**Technology**	Development Adaptation of EHR and/or Care Management System	Chose new and existing data sets for our exisitng EHR that will improve data collection among CSA staff	Data sets for a dashboard to drive workflow changes are identified and/or created			Dashboard that drive workflow changes is implemented and shared with CSA staff	Utilization of CSA dashboard has begun		
4	Leverage and expand technology to capture, analyze and share relevant data	provide all ICC staff with new netbooks	01/01/18	05/31/18	**Technology**	Technology for Service Delivery	Purchase netbooks for all ICCs	Netbooks have been purchased			All netbooks for ICCs are deployed	ICCs are using netbooks daily in the field		
1	Workforce Recruitment Improves Timely Access	create and implement strategic recruitment and talent branding campaign to increase # of Masters-level ICCs	01/01/18	12/31/21	**Workforce Development**	Workforce Development staffing including Fringe	Identify and train .5 Talent Acquisition Specialist	Clinical Talent Acquisition Specialist works with support staff to plan recruitment and talent branding campaign			Implement recruitment and talent branding campaign	Increase # of applications for ICCs by 10%		
1	Workforce Recruitment Improves Timely Access	create and implement strategic recruitment and talent branding campaign to increase # of Masters-level ICCs	01/01/18	12/31/21	**Workforce Development**	Workforce Development staffing including Fringe	Marketing and HR departments create draft recruitment and talent branding peripherals	Draft peripherals are reviewed by CSA senior management and new Talent Acquisition Specialist			Recruitment and talent branding peripherals (print and digital) are deployed.	At least 500 print pieces have been put into the community and at least 500 social media impressions have ocurred for this campaign.		
3	NWIC Wraparound Coaching "Boosters" and CSA Leadership Support & Training	further strengthen fidelity to Wraparound proccesses specifically in areas reflected in our fidelity scores and provide ongoing direct support to the CSA leadership team for sustainability	01/01/18	12/31/19	**Workforce Development**	Training Expenses	All 2018 trainings--on-site "booster" and Leadership staff attending NWIC Academy--are scheduled.	CSA training calendar for 2018 completed.			On-site "Booster" training provided to CSA staff.	CSA staff increase understanding of high-fidelity Wraparound		
2	Community Outreach	create and implement work plan for outreach to ACOs and PCPs	01/01/18	12/31/22	**Operational Infrastructure**	Operation Staffing including Fringe	Identify and train Community Outreach Specialist	Community Outreach Specialist completes UMASS Integrated Care Management certification			Community outreach workplan implemented	Number of PCPs and ACOs receiving fact to face contact increases		

Section 6.2 Executive Summary

A. Bidder's current performance on its Development Plan:

YOU, Inc. has identified several areas to focus on through its development plan. These include reducing the timeframe for an intake date for families that are referred to the program. This is directly related to the issue of timely access to ICC services. Another goal in the current development plan is to improve fidelity scores in four areas: outcome measurement, natural supports, youth engagement and facilitation skills. This is directly related to improving fidelity to wraparound. Another goal is to improve/enhance the training coaching process for Family Partner staff through the implementation of observation tools. This is directly related to improved coaching and training of staff. YOU, Inc.'s progress on its development plan has seen periodic gains on reducing the waitlist. This has been impacted, however, by staff turnover, which results in increases in the waitlist. Numerous efforts have been made to reduce turnover but have not been able to be sustained. It is anticipated that through this funding initiative long term impact can be made in this area of staff recruitment and retention.

Areas on the development plan where goals have been met include improving the quality of progress notes and assessments by staff, completed and implemented standardized initial training for all staff as well as the implementation of observation tools for the ICC staff.

B. Strengths and Needs of the Bidder:

A strength demonstrated by the YOU, Inc. CSA program has been the level of integration of both school and medical staff into the System of Care meetings. We have seen a greater interest from several of the pediatric practices in the area to become more involved with CBHI services. We have continued to work well with the many school districts in our catchment area. We have also developed a very strong relationship with both DCF and DMH staff. With our participation, DCF created an interagency group to foster better communication and collaboration. Despite some ongoing issues regarding staff retention, we have numerous ICC staff who have remained in their roles for over three years and some for over 7 years. The other strength of our CSA has been the willingness of staff to take on implementing the ARC GROW model into the wraparound model. This has enabled staff to better educate parents on understanding the impact of trauma on their children.

Another strength of YOU, Inc. is our the recent leadership that we have taken in creating and running ADVANCE, a behavioral health professional development collaboration with Assumption College and four other agencies. This initiative, first funded externally and now embedded in our organizational structure, helps professionals earn Masters degrees at a reduced tuition, benefitting both the individual and the behavioral health workforce. While we have taken the lead in workforce development with this initiative, more needs to be done,

hence why two of the four proposed projects for DSRIP funds are meant to improve both the number of ICCs and their expertise in wraparound fidelity.

Needs of the bidder would focus on recruitment of staff in order to provide timely access to services, as well as efforts to enhance staff development in order to impact staff retention. Other needs include further training of staff in collaborating with medical personnel and strengthening the relationships with PCPs in the communities that we are located. Although we have a well-developed Electronic Health Record for the CSA program, a critical need for enhancing data analysis now exists. Finally, the development of a sustainable coaching system would ensure continued training and fidelity to the wraparound model.

It should be noted that the four projects that we outline in section 6.4 are geared to address the need areas for the program. By receiving funding for these projects, YOU, Inc. would be able to prepare the CSA for a greater role in the new system under MassHealth and working collaboratively with ACOs.

C. Plans for improving timely access to ICC services

Timely access to ICC services will be improved through the development of a strategic recruitment and marketing plan to acquire talented staff. In order to maintain timely access to ICC services, we need to ensure a greater capacity of ICC staff so that families can be assigned to an ICC within a reasonable timeframe from referral. A plan to dedicate a staff person just to focus on recruiting ICC staff and to purchase needed marketing materials would greatly enhance current efforts to fill ICC positions. YOU, Inc. has a Central Referral system that ensures a quick turnaround time for referrals to be triaged and sent to be assigned by the program. See section 6.4 project description of workforce development for a more detailed description of staff recruitment efforts.

D. Plan for improving care coordination, care planning and care management for ICC-Engaged Members

The plan to improve care coordination, care planning and care management is directly tied to the project that is outlined in section 6.4 to develop a system of coaching certification for all ICC staff. This will be done by contracting with Vroon VDB, a nationally recognized wraparound coaching and training group from Colorado. By training our senior managers and supervisors to be certified as coaches we will have the ability to provide wraparound certification for our staff, and to ensure a greater level of fidelity to the wraparound model and improve the work that the ICC staff do in care coordination and care planning. This will be an investment in sustaining a system of coaches within our own agency that can maintain this training on an ongoing basis. Research has demonstrated that this train the trainer model has consistently provided greater fidelity over a sustained period of time.

E. Plan to improve performance on quality scores and development plan goals.

This plan again centers on the projects as outlined. By improving recruitment of staff and improving fidelity to wraparound through enhanced coaching, quality scores and development plan goals will be improved. Certification of coaches on staff will have a long lasting impact on the training of ICC staff and therefore, in the quality of wraparound being provided to ICC engaged members. Through monitoring of WAFAS scores, we will be able to monitor the progress on quality scores. The program will also utilize the transition indicator tools to measure progress of families in the program.

F. Plan for improving coordination with pediatric primary care and other physical and behavioral health care providers across the care continuum for youth.

The plan for improving this coordination is tied to the enhancement to the program of a community outreach specialist who will focus their energies completely on the furthering of our relationships with PCPs and other healthcare providers. We have already begun developing some strong relationships in each area (Milford/Southbridge) and expect to be able to build upon these relationships to further develop additional collaborations. We already work closely with all the behavioral health providers as our ICC staff work collaboratively with many providers on care planning teams with our families. By adding this dedicated staff time to this project we will be able to greatly improve this area of collaboration. See section 6.4 for more detailed description of the role of the community outreach specialist.

6.3 Populations Served and Community Engagement

A. Member Populations and Communities Served

The YOU, Inc. Community Service Agency (CSA) program services the South Central area, which encompasses a large part of Southern Worcester County. This area covers from Franklin on the eastern side of the catchment area to Sturbridge on the western side. The largest towns within the area are Southbridge, Webster, Northbridge, Milford and Franklin. There are also a number of smaller communities that are generally rural in nature. The highest number of ICC members are concentrated in the communities listed above.

Due to the large geographic nature of this area, YOU, Inc. has established two office sites to enhance our outreach to all towns in this catchment area. One office is located in Milford at 221 East Main Street and the other in Southbridge at 328 Main Street. School data for Southbridge and Webster reflect a high percentage of economically disadvantaged students. In Southbridge the percent of students identified as economically disadvantaged is 61% compared to a statewide average of 27%. In Webster, the percentage of students identified as economically disadvantaged is 46% compared to statewide average of 27%. The other important factor in Southbridge and Webster is the high percentage of Hispanic/Latino students. In Southbridge the percentage is 50.5% compared to a statewide average of 18.6%. In Webster the percentage is 20% which is slightly higher than the statewide average. This has resulted in a greater demand for bilingual Spanish speaking staff, as many parents of eligible members do not speak English or feel more comfortable communicating in their first language.

Currently, of the 134 families, YOU, Inc. serves in its CSA program, 23% of the families report being Hispanic or Latino. Both the Southbridge and Milford communities have a high percentage of Spanish speaking families. We currently have four bilingual staff between the two sites to help address this access issue.

In both the Southbridge and Blackstone Valley communities, we have worked closely with several pediatric practices. We have worked with pediatricians at the Harrington Healthcare system in Southbridge, including Dr. Anu Pathak, Dr. Cynthia Wilson-Grillo and Dr. Robert Giordano. We also held our System of Care committee meeting in November at Harrington Hospital in order to foster better communication and collaboration with the healthcare system. In Blackstone Valley, we have worked closely with Dr. Jeffrey Lukas from the TRI-River Family Health Center. Dr. Lukas has collaborated well with our ICC staff in Milford and has attended several Care Planning team meetings. We also held our System of Care meeting this past fall at the Tri-River Family Health Center and several of the pediatricians were able to attend that meeting. We believe the CSA program will be able to build upon these already established relationships with the additional staff input (from Plan # 4) and increase the number of pediatricians in the area that work with ICC staff. This will also enable staff to work more closely with medical personnel and our families to promote the health and well being of the

individuals we serve. It is anticipated that through regular communication with medical staff, our ICC staff will be able to identify areas for promoting health with the families of these members.

B. Relationships in Community to Leverage to Improve Quality of Service

The YOU, Inc. CSA Program has developed strong partnerships and relationships in the communities we serve. In the Blackstone Valley area, we collaborate closely with several Behavioral Health providers including Wayside Youth and Family Network, Family Continuity Programs, Riverside Community Care and Arbour outpatient services. We hold our System of Care meetings at the Whitin Community Center, which is a community recreational center as well as a child care provider. Our collaboration with them has created recreational opportunities for Therapeutic Mentors for several agencies in the area. We have developed a strong working relationship with the local DCF office in Whitinsville, which has included joint trainings for their staff and ours. We also participate monthly in an interagency meeting which includes probation staff from the Milford and Dudley courts, as well as staff from DMH and DDS. We have collaborated with both Parent Professional Advocacy League (PPAL) and the Kennedy Donovan Center in Milford to support an ongoing parent support group. Additionally, we are an active member of the Juvenile Advocacy Group (JAG) which works with community partners, including the Milford Youth Center to prevent substance abuse and address emerging needs in the communities of Milford, Bellingham and Hopedale.

In Blackstone Valley, we have worked with several school districts, particularly Milford, Northbridge and Franklin. We have made several presentations to Franklin school staff concerning behavioral health services and assisting staff in accessing CBHI services. As a result of this collaboration, Franklin schools have utilized the CSA services for many families in their community.

In the Southbridge and Webster areas, we have worked with several agencies including GB Wells and Harrington Healthcare system, as well as Wayside, FCP and South Bay Mental Health. In Southbridge, YOU, Inc. has participated directly with the school system and has worked with the receiver appointed by DESE, as well as a workgroup formed by DESE to create a plan for improvement for the Southbridge schools. This specifically included ways to improve access for the students to mental health services. YOU, Inc. also provides extensive behavioral health services in the area in addition to the CSA program. We provide Outpatient Therapy, In-Home Therapy, Therapeutic Mentoring, as well as IHBS services. ICC staff also coordinates care with individuals receiving mental health services from GB Wells, the outpatient department of Harrington Healthcare.

Additionally, YOU, Inc. manages a contract with the Department of Youth Services to provide their District office in Webster with Youth Service Coordinators, and we have formed a close working relationship under this contract. The youth service coordinators ensure DYS clients

access appropriate mental health services, including ICC services when needed. YOU, Inc. through this contract provides casework support to DYS youth throughout the Southern Worcester County, as well as the rest of Worcester County.

C. How Current and Planned Partnerships Align with Bidders' Proposed Projects

Our current partnership with Tri-River Family Health Center (FHC) will be greatly enhanced by the implementation of a community outreach specialist to improve access and communication for eligible members. Tri-River FHC is a part of the UMass Memorial Healthcare system which will also be providing ACO services. It is planned to expand this relationship as a way to bridge further development of YOU, Inc.'s connection to the ACO organization.

One of our proposed projects is to provide coach certification in wraparound in order to improve fidelity of ICC staff to the wraparound model. Our current collaboration with other CSA's in the central region will enable us to bring in wraparound trainers to provide this certification and to provide a train the trainer model which will enhance the sustainability of this project. During this past year, we have provided shared trainings with Community HealthLink and Wayside to enhance the trainings available for both ICC and FP staff in the region.

One other very important partnership is YOU, Inc.'s participation with the Southern New England Practice Transformation Network. This collaborative is led by UMass Medical School and UConn Health. This participation is geared to helping our clinical practices be better prepared for transforming our practice in line with changes being made, such as alternate payment methodologies and greater use of technology in providing clinical care for consumers.

We believe this process will enable us to better identify target areas of practice transformation to focus on, as well as to identify strengths the organization will bring to this critical work. Furthermore, this will help us in our continued use of technology and the expansion of our technology planned under this grant.

Section 6.5 Coordination with ACOs, MCOs and Primary Care Providers

A. **Bidirectional communication between the Bidder and pediatric practices**
As detailed in Section 6.4, Proposed Project and Investment Plan, the agency intends to improve collaboration, communication and coordination with PCPs and ACOs by utilizing DSRIP funding to staff a Community Outreach Specialist position. The COS role is to target (1), **ongoing networking and relationship building with ACOs and PCPs, (2) comprehensive education concerning CSA and its wraparound services, and (3) improving the coordination and integration of services across these systems of care for ICC-engaged members.** Presently, the CSA Program Director participates in ongoing planning and informational meetings with MCOs, (MBHP and Beacon/Fallon Regional Coordinators) on a quarterly basis. These meetings provide networking opportunities, time to strengthen working relationships and ongoing bidirectional communication. The focus of most meetings is to revisit Development Plans, discuss waitlists, analyze CANS reports and note successes. In addition, member files are reviewed. We have been fortunate to have established a long-term and productive relationship with the two Regional Coordinators. In between meetings, ongoing electronic and telephone communication occurs regularly.

B. **Referral management protocols for follow-up and informational sharing**
YOU, Inc. utilizes a Central Referral department that receives referrals and directs them to the appropriate service. Pediatricians and other healthcare and behavioral healthcare providers frequently call to both make referrals and to check on the status of clients previously referred. They can reach the Central Referral and intake specialists from 8:30am to 5:30pm each business day through email and telephone. They receive a response within 24 hours. However, no confidential client information or even their status on the waitlist can be discussed unless there is a Release of Personal Health Information on file. In addition, anyone making a referral must complete a comprehensive referral form. This information is used to confirm which program can best serve a client's needs, allows Central Referral to check insurance and includes all contact information. This information is forwarded to the program. In the case of the CSA Program, once this information is received, senior care coordinators manage the referral waitlist and assign cases to the ICCs and Family Partners. Once the case is assigned, the ICC works with the family to foster good communication between them and their care providers. Other opportunities to share information happen at the family "Wrap" meetings where all providers are invited to participate. To further support these efforts to maintain good communication we are proposing that the Community Outreach Specialist acts as an expediter whenever there is a misunderstanding in the two-way communication.

C. **Team-based treatment planning in collaboration with pediatric practices**

The CSA model is based primarily upon the team approach and relies on collaborative systems of care and natural family supports to assist the team in a concerted effort to partner with families for the best possible outcomes. It can be challenging to coordinate multiple healthcare and behavioral health entities, but it is so important to have them at the table to jointly treatment plan. We have recognized over the years that pediatrician offices, for an example, play a critical role in the lives of our families, but that it is difficult for the doctor to attend outside meetings because of their schedule. Instead our ICCs reach out to nurse practitioners and social workers who are often part of pediatric practices. In turn, our Family Partners coach parents and caregivers how to navigate medical systems successfully. To further strengthen this team approach we will ensure that our ongoing CSA trainings continue to focus on macro efforts to impact team based treatment planning. The role of our proposed Community Outreach Specialist fits nicely into this plan.

D. Timely access to ICC services

The timely access to ICC services is our priority. To that end we are proposing a comprehensive workforce recruitment and marketing plan as one of our proposed projects in Section 6.4. This plan will increase the number of ICCs and decrease our CSA waitlist, which is currently at an all-time high.

E. Connections to social services

We are fortunate in both the Milford and Greater Southbridge areas and across all agency programs to have established a broad spectrum of resources to assist us in our provision of services to families, children and adolescents. The CSA in particular participates in numerous coalitions, naturally occurring team and "wrap" meetings and partners with multiple providers in identifying and making referrals to available services. Our Centralized Referral Center keeps a database of provider services and our Community Connections and Family Resource Center sends out agency-wide information on new social service programs as well as notifications on upcoming community events. Our team consists of many seasoned professionals possessing a wealth of available natural and creative connections. Finally, our agency alone has a wide continuum of programming and strong connections with public and private entities such as DCF, DMH, DPH and DTA.